

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 7 6 9 7 | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| THOMAS W BAILE | | | | 3 26 81 | | | | 0600 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS | | 7. IF UNDER 1 YEAR | | 7b. IF UNDER 72 HRS | |
| MALE | | WHITE | | 1 28 1911 | | 70 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Mid | | U.S.A. | | | | Carroll MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Westminster | | 338 Ridge Rd | | | | Plumber | | Plumbing | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | |
| Mid | | | | Carroll | | Westminster | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 338 Ridge Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| WALTER BAILE | | | | ROMAINE STULTZ | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT, ADDRESS | | | | | |
| NO | | | | NONE | | GENEVIEVE BAILE 338 Ridge Rd 21159 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1629 RESP. FAIL. | | | | | | | | HRS. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| SQUAM. CA - LUNG | | | | | | | | 18 MOS. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| CIGARETTE SMOKING | | | | | | | | YRS. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ to _____ | | | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. DATE SIGNED | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB. 1980 to MARCH 81 | | | | M. Susan Bockinger MD | | 3/26/81 | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22c. DATE SIGNED | | 22d. ADDRESS | | | | | |
| M. Susan Bockinger | | | | 3/26/81 | | WASH. HGS. MED. CTR. WESTMINSTER, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 3-28-81 | | Pine Grove | | 24. FUNERAL DIRECTOR NAME Robert E. Pratt Jr. Westminster, Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | | | |
| Robert E. Pratt Jr. | | | | MAR 30 1981 | | | | | | | |

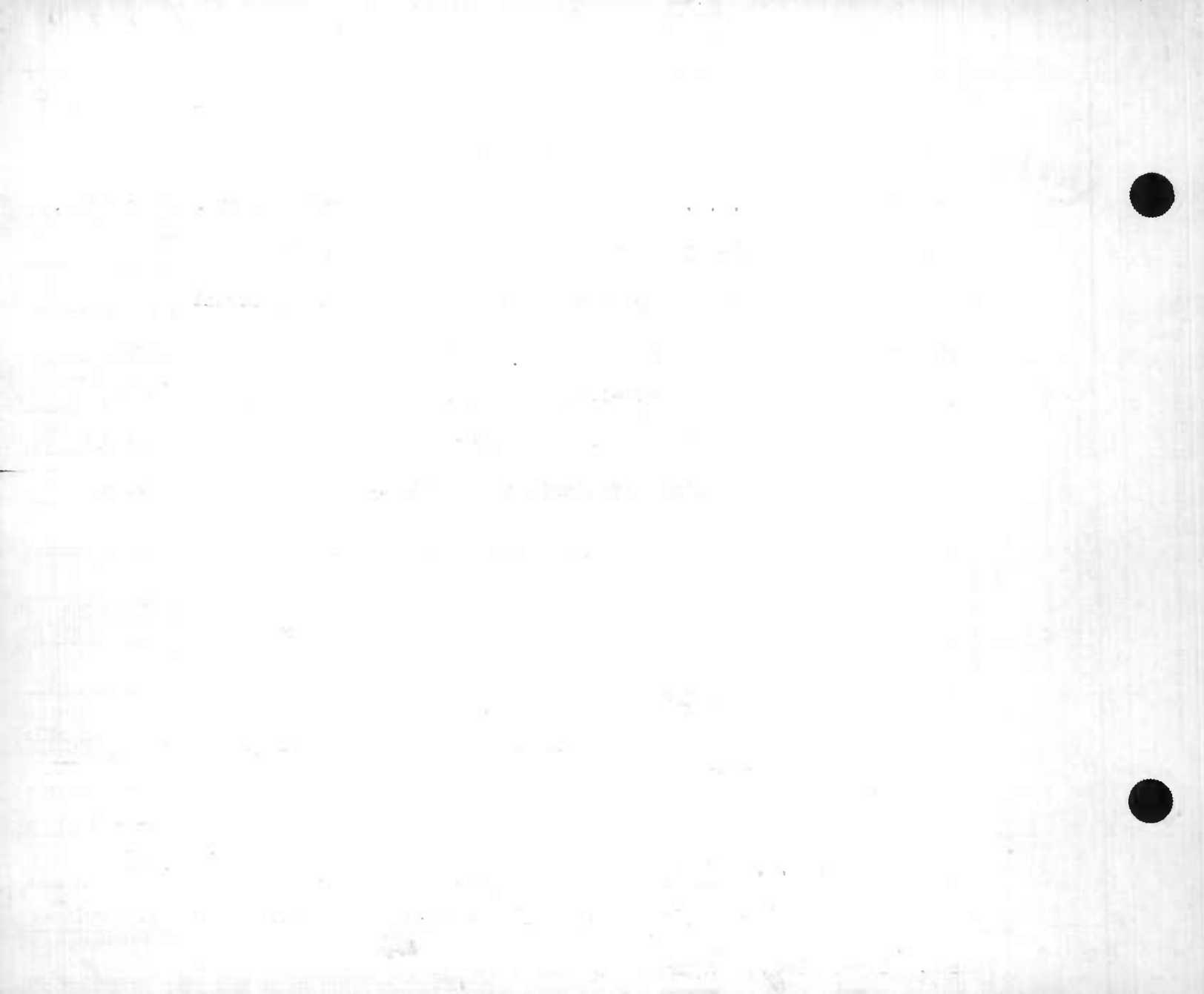
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Alvina NMN Baker | | | 2a. DATE OF DEATH MONTH DAY YEAR 03-04-81 | | | 2b. HOUR 11:58 PM | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 07-07-94 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | | 8. IF UNDER 24 HRS HOURS MIN. YRS. | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, Sykesville, Md. | | | | | |
| 13. CITY OR TOWN OF DEATH Sykesville | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center | | | | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework | | 16. KIND OF BUSINESS OR INDUSTRY | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland | | 17b. COUNTY Washington | | 17c. CITY OR TOWN Hagerstown | | 17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17e. STREET ADDRESS 350 Vista Street | | | |
| 18. FATHER'S NAME FIRST MIDDLE LAST Everhart Loudenslager | | | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Yeuch | | | | | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 21. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-5539 | | 22. INFORMANT ADDRESS Sykesville, Maryland Records, Springfield Hospital Center, | | | | | | | |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the colon | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) with metastasis to the liver DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 24. DATE OF OPERATION | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 33. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 34. I certify that (I) (this hospital) attended the deceased from 12-05- 19 25 , to 03-04- 19 81 , that (I) (we) last saw the deceased alive on 03-04-81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 35. SIGNATURE Suha Ozgun, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 36. DATE SIGNED 3-5-81 | | | |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT) Suha Ozgun, M.D. | | | | 38. ADDRESS Springfield Hospital Center Sykesville, Maryland 21784 | | | | | | | |
| 39. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 40. DATE March 9, 1981 | | 41. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 42. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | | | |
| 43. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | 44. DATE REC'D. BY REGISTRAR MAR 10 1981 | | 45. REGISTRAR'S SIGNATURE | | | |

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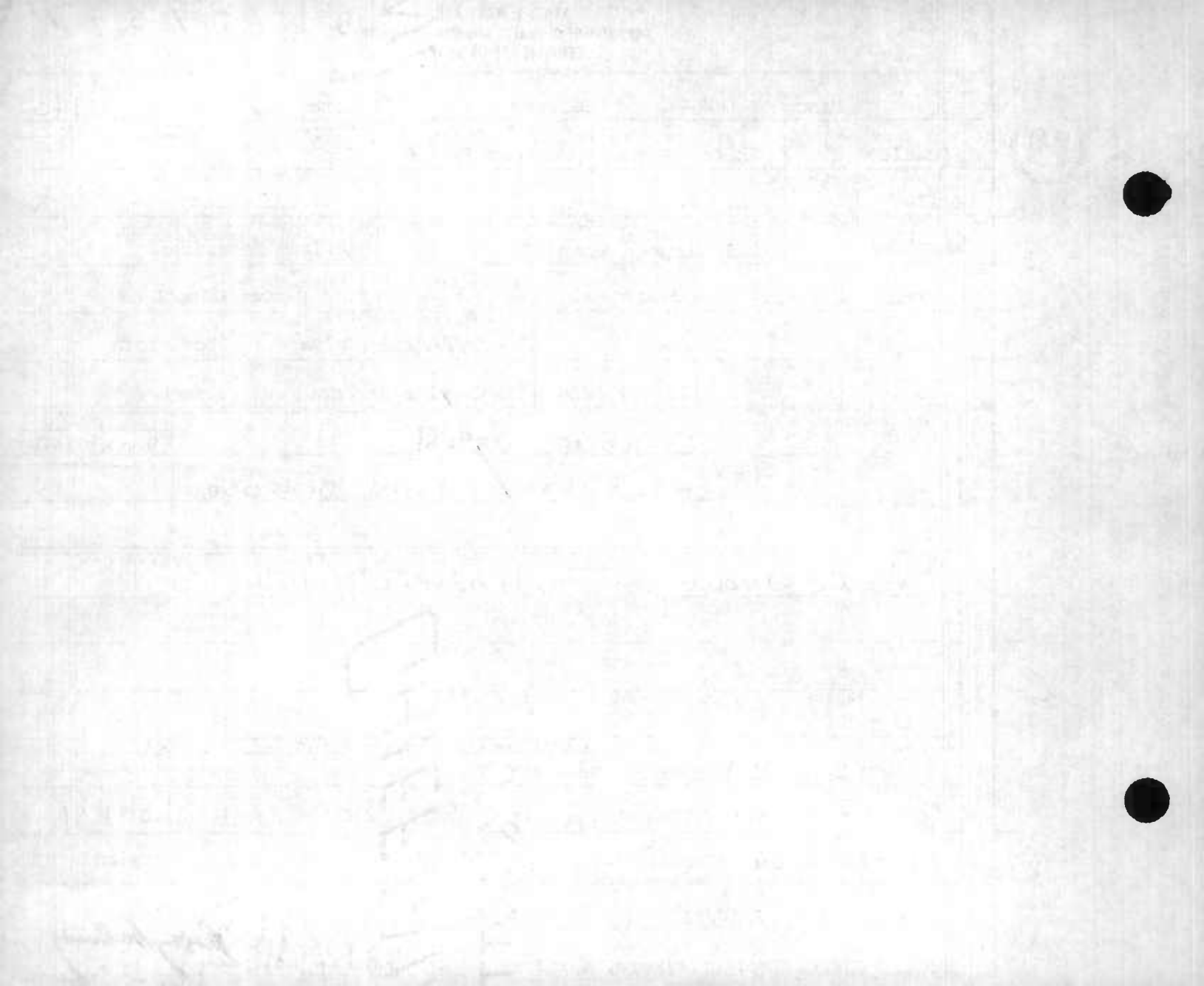
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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nancy (Nunza) Barbera | | | 2a. DATE OF DEATH MONTH DAY YEAR March 11, 1981 | | 2b. HOUR 17 10 M | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR January 1, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD. | | |
| 10. CITY OR TOWN OF DEATH Hampstead | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2215 Harvey Gummel Rd | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Seamstress | | |
| 13a. STATE Maryland | | | 13b. COUNTY Carroll | 13c. CITY OR TOWN Hampstead | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Romano | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carmelita Palma Commarata | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-01-8414 | | 17. INFORMANT ADDRESS Mr Charles Barbera Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Aortic aneurysm, Diabetes Mellitus.</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-12-</u> 19 <u>79</u> to <u>3-11-</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3-9-</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>Chitrachedu Naganna M.D.</u> | | DEGREE MD | | 22c. DATE SIGNED 3/11/81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU Naganna M.D. |
| 22e. ADDRESS 174 Main St Westminister, Maryland | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/14/81 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland |
| 24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR MAR 12 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Robert M. Ruck</u> | | |

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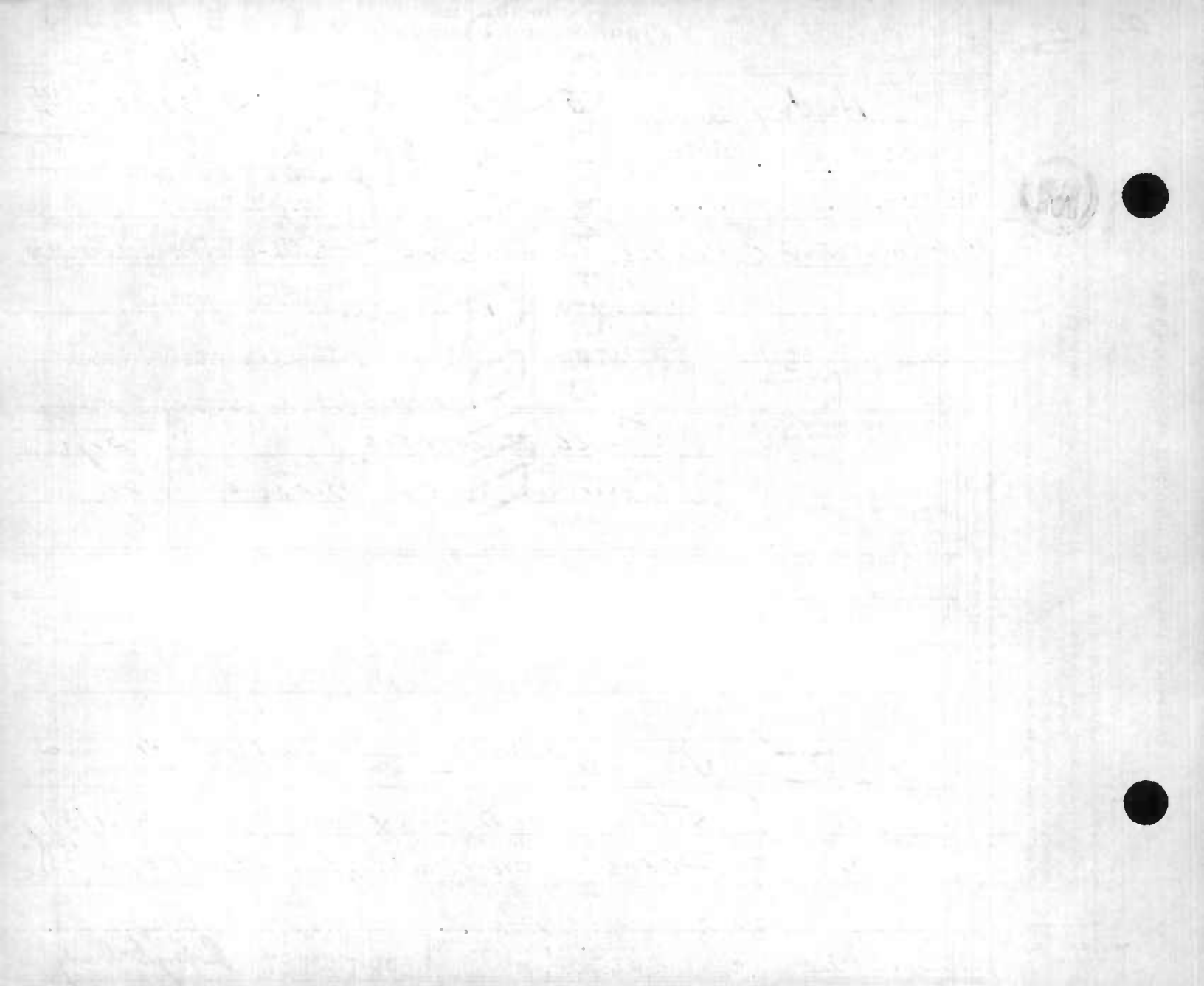


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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--------------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Audrey Virginia BISHOP</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>3/31/81</i> | | 2b. HOUR <i>18⁴⁵ A</i> | | |
| 3 SEX <i>FEMALE</i> | | 4 RACE <i>NEGRO</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>3 16 18</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>62</i> | | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Box Iron, Md.</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD | | | |
| 10 CITY OR TOWN OF DEATH <i>WESTMINSTER</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CARROLL CO GENERAL</i> | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>domestic-laborer</i> | | 12b KIND OF BUSINESS OR INDUSTRY <i>housekeeper</i> | |
| 13a STATE <i>Maryland</i> | | 13b COUNTY <i>Carroll</i> | | 13c CITY OR TOWN <i>Westminster</i> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS <i>22 Fitzhugh Avenue</i> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>William Edward Bishop</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Elizabeth Johnson</i> | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS <i>Mrs. Louise Spittell same as above</i> | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CAARCINOMATOSIS</i> <i>1749</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yr</i> <i>25</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>3/31</i> , 19 <i>81</i> , to <i>3/31</i> , 19 <i>81</i> , that (I) (we) lost <i>saw</i> the deceased alive on <i>3/31</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>John E. Steers</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>3/31/81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John E. Steers</i> | | 22e. ADDRESS <i>210 Washington Hts. Westminster Md.</i> | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>4/4/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Coolspring U.M.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Girdletree Worcester Md.</i> | | | |
| 24 FUNERAL DIRECTOR NAME <i>Jolley Memorial Chapel</i> | | ADDRESS <i>Salisbury, Md</i> | | 25a DATE REC'D. BY REGISTRAR <i>APR 13 1981</i> | | 25b REGISTRAR'S SIGNATURE <i>Barbara McBratney</i> | | | |

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|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | 7 1 0 7 7 0 1 | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) JAMES A. BLACK | | | | 2a. DATE OF DEATH MONTH DAY YEAR March 25, 1981 | | 2b. HOUR 17 55 M | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR February 16, 1917 | | 6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS 17 55 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Valls Creek W.V. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD. | | | |
| 10 CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hospt. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Worker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. | | 13b. CITY OR TOWN Balto. | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 35 Westminster Road | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST James D. Black | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Miles | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 232-12-3705 | | 17 INFORMANT ADDRESS Mrs. Marie M. Black Reisterstown, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 17 E. Main St. Westminster MD 21157 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-23-1981 to 3-25-1981 , that (I) (we) lost saw the deceased alive on 3-25-1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Chitra Chandra Nagananna | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3-25-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHANDRANAGANNA | | | | 22e. ADDRESS 17 E. Main St. Westminster MD 21157 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE March 28, 81 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Md. | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md. 21136 | | | | 25a. DATE REC'D. BY REGISTRAR MAR 27 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

March 22, 1961

BLACK

WHITE

6A

February 16, 1917

White

Male

Carroll Co.

X

USA

Valle Creek W.V.

Construction Worker

Carroll Co. Gen. Hosp.

Westminster

32 Westminster Road

Restoration

Belto.

Id.

Wiles

Adrian

Black

D.

James

232-15-3705 Mrs. Marie M. Black Westminster, Md.

No

Yinshang, Md.

Evergreen Memorial

March 28, 61

Funeral

Elm Funeral Home Westminster, Md. 21156

MAR 27 1961

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 1 0 2 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lily V. Bosley</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>3/17/81</i> TIME HOUR <i>1830</i> M. | | | |
| 3 SEX <i>Female</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>3/17/91</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MINS <i>90</i> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD. | |
| 10 CITY OR TOWN OF DEATH <i>Westminster</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll Co. General Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Greif Co.</i> | |
| 13a. STATE <i>Md.</i> 13b. COUNTY <i>Balto Co.</i> 13c. CITY OR TOWN <i>Upperco</i> | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> # <i>15993</i> | | 13e. STREET ADDRESS <i>Trenton Rd</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>James Naylor</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Hsie</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>219-34-4478</i> | | 17. INFORMANT ADDRESS <i>Mr. Calvin Bosley Upperco, Md. 21155</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4140 Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 16, 1981</i> to <i>March 17, 1981</i> , that (I) (we) last saw the deceased alive on <i>March 17, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>John S. Harsney, M.D.</i> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>3/18/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN S. HARSNEY, M.D.</i> | | | | 22e. ADDRESS <i>8 Anchor St. Westminster, Md. 21157</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>March 20, 81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Upperco, Md. 21155</i> | |
| 24. FUNERAL DIRECTOR <i>Eline Funeral Home</i> NAME ADDRESS <i>Hampstead, Md. 21074</i> | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAR 23 1981 [Signature]</i> | | | |

17

17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 7 0 3 | |
|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Paul Wesley Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR March 3, 1981 | | 2b. HOUR 6 P.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1907 | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | IF UNDER 1 YEAR MONTHS DAYS 11 16 | IF UNDER 24 HRS. HOURS MIN. 16 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD. | | |
| 10. CITY OR TOWN OF DEATH Mt. Airy | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 307 Bellview Ave. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Black-smith | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY Carroll | 13c. CITY OR TOWN Mt. Airy | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Guy (NMN) Brown | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie V. Hood | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-5433 | 17. INFORMANT ADDRESS 307 Bellview Ave. Mrs. Lorraine Foreman, Mt. Airy, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hypertensive and Atherosclerotic</u> <u>4029</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October, 1976</u> to <u>March, 1981</u> , that (I) (we) last saw the deceased alive on <u>Jan. 14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>W.B. Culwell MD</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>March 4, 1981</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Culwell | | 22e. ADDRESS 4 Culwell Drive Mt. Airy, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-6-1981 | 23c. NAME OF CEMETERY OR CREMATORY Prospect | | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Md. |
| 24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md. | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | |



NOTICE OF SALE

Charles A. Carter, Jr., Sheriff, Shelby County, Tenn.

Shelby County, Tenn.

Notice of Sale

21

Shelby County, Tenn.

Notice of Sale

Shelby County, Tenn.

Notice of Sale

Shelby County, Tenn.

Notice of Sale

Shelby County, Tenn.

Notice of Sale

Shelby County, Tenn.

Notice of Sale

Shelby County, Tenn.

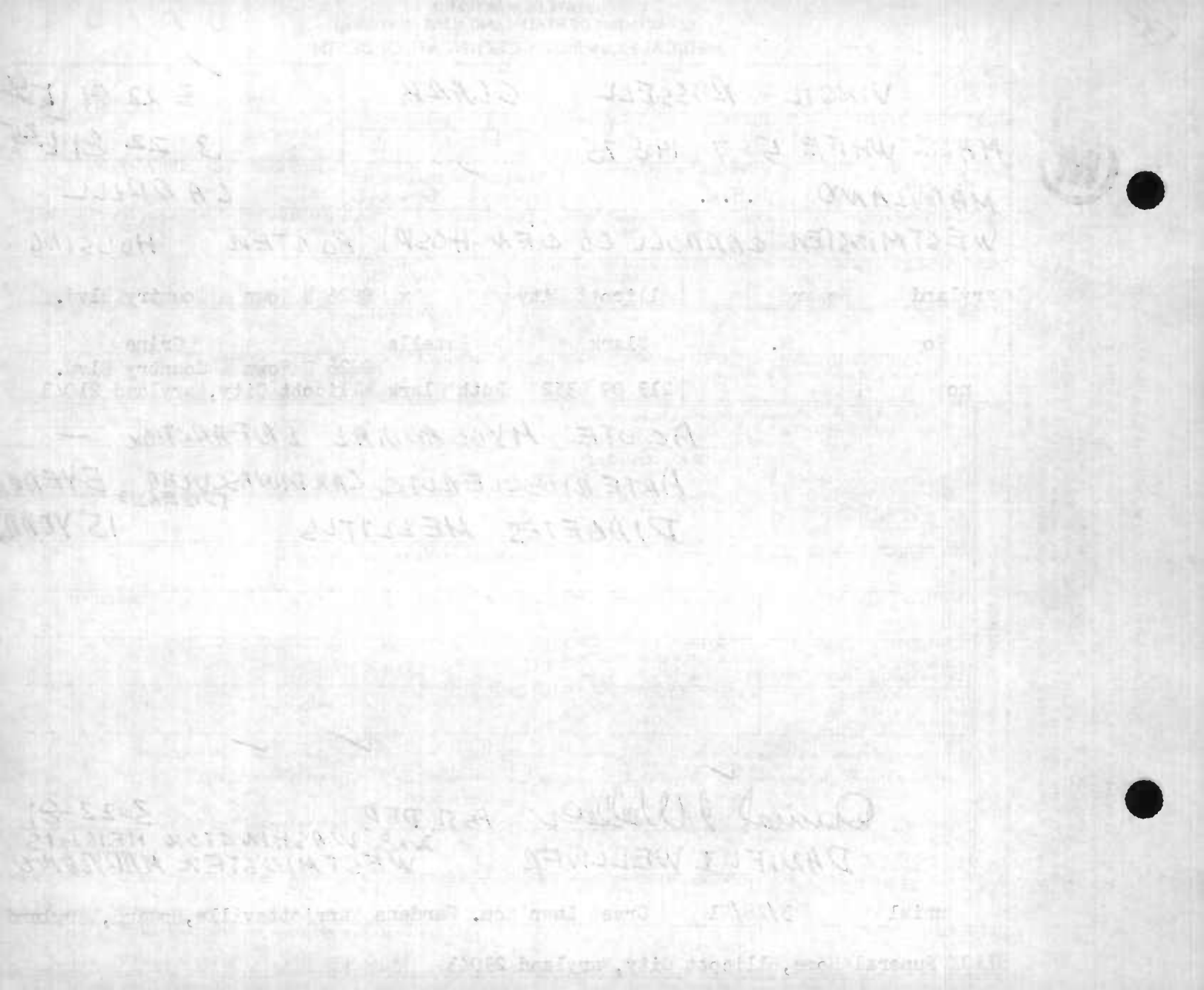
Notice of Sale

Shelby County, Tenn.

Notice of Sale

Shelby County, Tenn.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|---------------------------------|--|--|--|---|--|
| FOR STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 07704 | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) VIRGIL RUSSELL CLARK | | | | | | 2a. DATE KNOWN OF DEATH 3 22 81 | | | | | | 3. HOUR 5 | | | | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 5 7 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 3 22 81 | | 4. HOUR 6 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH WESTMINSTER | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL GO GEN HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PORTER | | | | 12b. KIND OF BUSINESS OR INDUSTRY HOUSING. | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Ellicott City | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8826 B Town & Country Blvd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Roy R. Clark | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Grine | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 213 09 6352 | | | | 17. INFORMANT Ruth Clark | | | | 8826 B Town & Country Blvd. Ellicott City, Maryland 21043 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| IMMEDIATE CAUSE (a) 2500 | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | 5 YEAR | | | | | | | |
| (b) DIABETES MELLITUS | | | | | | | | | | | | 15 YEAR | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Daniel I Welliver | | | | TITLE (SPECIFY) M.D. ASST DEP | | | | MEDICAL EXAMINER DATE SIGNED 3-22-81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) DANIEL I WELLIVER | | | | ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MARYLAND | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 3/26/81 | | 23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Mem. Gardens | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville, Howard, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 30 1981 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |



Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 7 0 5 | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1- REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST Raymond T CROSS | | | | MONTH DAY YEAR Mar 23, 1981 | | | | 23 00 M | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | |
| MALE | | BLACK | | MONTH DAY YEAR Sept 7 1904 | | 76 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | USA | | | | CARROLL MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Westminster | | CARROLL Co General | | | | Sabor | | General | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md CARROLL Westminster | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 46 CHARLES STREET | | | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST Joseph CROSS | | | | FIRST MIDDLE LAST Ella MYERS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | | | ADDRESS | |
| No | | | | None | | 219-01-7714 MARY CROSS | | | | Westminster, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma | | | | | | | | | | | |
| 1889 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/14/81, 19 81, to 3/23 19 81, that (I) (we) last saw the deceased alive on 3/23 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| John S. Harsney, MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 3/23/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| JOHN S. HARSNEY, MD | | | | 8 Archer St. Westminster, Md. 21157 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 3-28-81 | | White Rock | | JACKESVILLE CARROLL MD | | | |
| 24 FUNERAL DIRECTOR | | | | 25a. DATE RECEIVED BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert Kyle Priddy, Jr. Westminster, Md. | | | | MAR 30 1981 | | | | [Signature] | | | |

BP

Don't forget to check the
2-68 81 White Truck
Sylvanville (Carnall) 7/14

no more 519-01-7111 Mary Carr
Sylvanville 3/11/3
Carnall Westminister
✓ Westminister Carnall Co General
Sylvanville 3/11/3
Carnall

no more 519-01-7111 Mary Carr
Sylvanville 3/11/3
Carnall Westminister
✓ Westminister Carnall Co General
Sylvanville 3/11/3
Carnall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1 DECEASED NAME FIRST MIDDLE LAST Lena C. Croucher | | | | 3 26 81 | | | |
| 3. SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 4 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD. | |
| 10 CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1326 Deerpark Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Ulysses S. Grant | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Eckes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-07-8813 | | 17. INFORMANT ADDRESS Carolyn N. Auvil 7814 Kavanagh Road Balto., MD. 21222 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G-I. Bleeding</u> 1590 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intestinal Ca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>A.S.H.D. ; ANEMIA ; SEVERITY</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-18</u> 19 <u>81</u> to <u>8-26</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3-23</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>M. J. Sevilla</u> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3-26-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL J. SEVILLA | | | | 22e. ADDRESS 419 C MALCOLM DR. WESTMINSTER, MD. 21157 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/30/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR MAR 30 1981 | | 25b. REGISTRAR'S SIGNATURE <u>P. H. [Signature]</u> | |



20% COTTON
FIVE 1/4



MAR 00 1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07707 | |
|--|--|-------------------------|--|--|--|--|--|--|--|--|--|--|--|---|--|---|--|--|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Bernice Marie Doss</i> | | | | | | | | | | 20. DATE KNOWN OF DEATH ESTI-MATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>3 3 1981</i> | | | | | | | | | | 21. HOUR <i>M</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH <i>July</i> DAY <i>27</i> YEAR <i>1927</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY)) <i>53</i> YRS. | | IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | | 7c. DATE PRONOUNCED DEAD <i>3 3 1981</i> | | 24. HOUR <i>11:15</i> <i>M</i> | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> <i>MD.</i> | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Westminister</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>30 Locust Street</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Carroll</i> | | | | 13c. CITY OR TOWN <i>Westminister</i> | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>30 Locust</i> | | | | | | | |
| 14. FATHER'S NAME FIRST <i>Guy</i> MIDDLE <i></i> LAST <i>Crist</i> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Florence</i> MIDDLE <i></i> LAST <i>Unknown</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i> | | | | 16b. SOCIAL SECURITY NO. <i>179 20 8409 A</i> | | | | 17. INFORMANT <i>Appt 404 Thomas J. Doss</i> | | | | 17b. ADDRESS <i>30 Locust St. Wsetminster Md.</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency, Severe Asthma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Chronic Bronchitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Possible Bronchial inhaler over usage</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 wk</i> <i>1 wk</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Possible Bronchial inhaler over usage</i> | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Richard A. Doss MD</i> | | | | TITLE (SPECIFY) <i>Deputy</i> | | | | MEDICAL EXAMINER <i>Carroll County, Bernad Hosp</i> | | | | DATE SIGNED <i>3 Mar 81</i> | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Richard A. Doss MD</i> | | | | ADDRESS <i>Westminister Md 21157</i> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>Mar. 6, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Mem. Gardens</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Gettysburg Adams Pa.</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Robert A. Meyer</i> ADDRESS <i>Willis St. Westminister Md. 21157</i> | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR <i>MAR 1981</i> | | | | 26. REGISTRAR'S SIGNATURE | | | | | | | |

RECEIVED

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SECRET

Page 60

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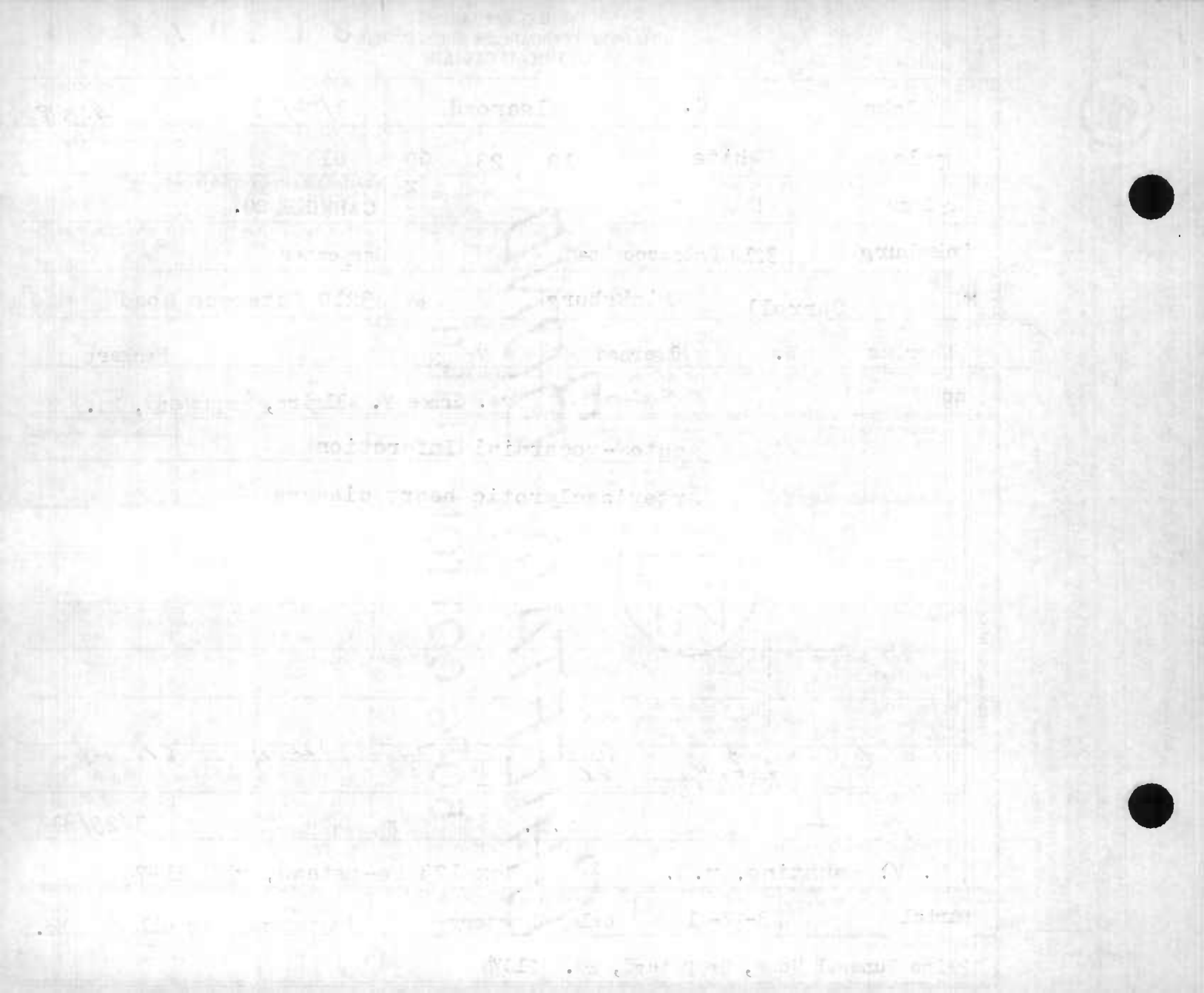
REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) John C. Elseroad | | 2a. DATE OF DEATH MONTH 3 DAY 24 YEAR 81 | | 2b. HOUR 4:15 P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 12 DAY 23 YEAR 99 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Finksburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3210 Patapsco Road | | 9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO. | |
| 10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Finksburg | |
| 14. FATHER'S NAME FIRST Charles MIDDLE W. LAST Elseroad | | 15. MOTHER'S MAIDEN NAME FIRST Fanny MIDDLE Bankert | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-2413 | | 17. INFORMANT Mrs. Grace M. Allgire, Hampstead, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from March 5 , 19 81 , to Feb. 4 , 19 81 , that (2) (we) lost saw the deceased alive on Feb. 11 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE D. V. Faustino, M.D. | | | | 22c. DATE SIGNED 3/25/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. V. Faustino, M.D. | | | | 22e. ADDRESS Box 173 Hampstead, MD 21074 | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | | 23b. DATE 3-27-81 | | 23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery | |
| 23d. LOCATION CITY OR TOWN Hampstead | | COUNTY Carroll | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074 | | | | 25a. DATE REC'D. BY REGISTRAR APR 3 1981 | |
| 25b. REGISTRAR'S SIGNATURE Dorothy McCreedy | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The [redacted] retained by the hospital or attending physician.

BP.



CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>ELISIE Maude EVERETT</u> | | | 2a. DATE OF DEATH MONTH <u>3</u> DAY <u>25</u> YEAR <u>81</u> | | | 2b. HOUR <u>7:40</u> P. M. | | | |
| 3 SEX <u>FEMALE</u> | | 4 RACE <u>WHITE</u> | | 5 DATE OF BIRTH MONTH <u>9</u> DAY <u>24</u> YEAR <u>94</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>86</u> YRS | | IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>XXXXXX Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>CARROLL COUNTY</u> MD | | | |
| 10 CITY OR TOWN OF DEATH <u>Mt. Airy,</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Pleasant View Nursing Home</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Teacher</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>xxxx Ed.</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>MARYLAND</u> | | 13b. COUNTY <u>Washington</u> | | 13c. CITY OR TOWN <u>Hagerstown</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>1028 Brinker Drive, #202</u> | |
| 14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>Luther</u> LAST <u>Sprecher</u> | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Myrtle</u> MIDDLE <u>Weaver</u> LAST <u>Weaver</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>219-12-1548</u> | | 17. INFORMANT ADDRESS <u>Janice L. Fisher, 1028 Brinker Dr.</u> | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>AC A SCUD WITH M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General Atherosclerosis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sec</u> <u>minutes</u> <u>7104rs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>TB (arrested post Rx) COPD, CBS, Arthritis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION <u>-</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>81</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>3/19</u> 19 <u>81</u> to <u>3/25</u> 19 <u>81</u> , that (I/we) last saw the deceased alive on <u>3/19</u> 19 <u>81</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Melvin Kordon MD</u> | | | DEGREE <u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>3/25/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Melvin Kordon</u> | | | 22e. ADDRESS <u>2000 Century Plaza Columbia MD 21044</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>3/28/81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hagerstown, Wash., Md.</u> | | |
| 24. FUNERAL DIRECTOR NAME <u>Rest Haven Funeral Chapel, Inc., Hag.,</u> | | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAR 30 1981</u> | | 25b. REGISTRAR'S SIGNATURE <u>Myrtle Weaver</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified.

BP

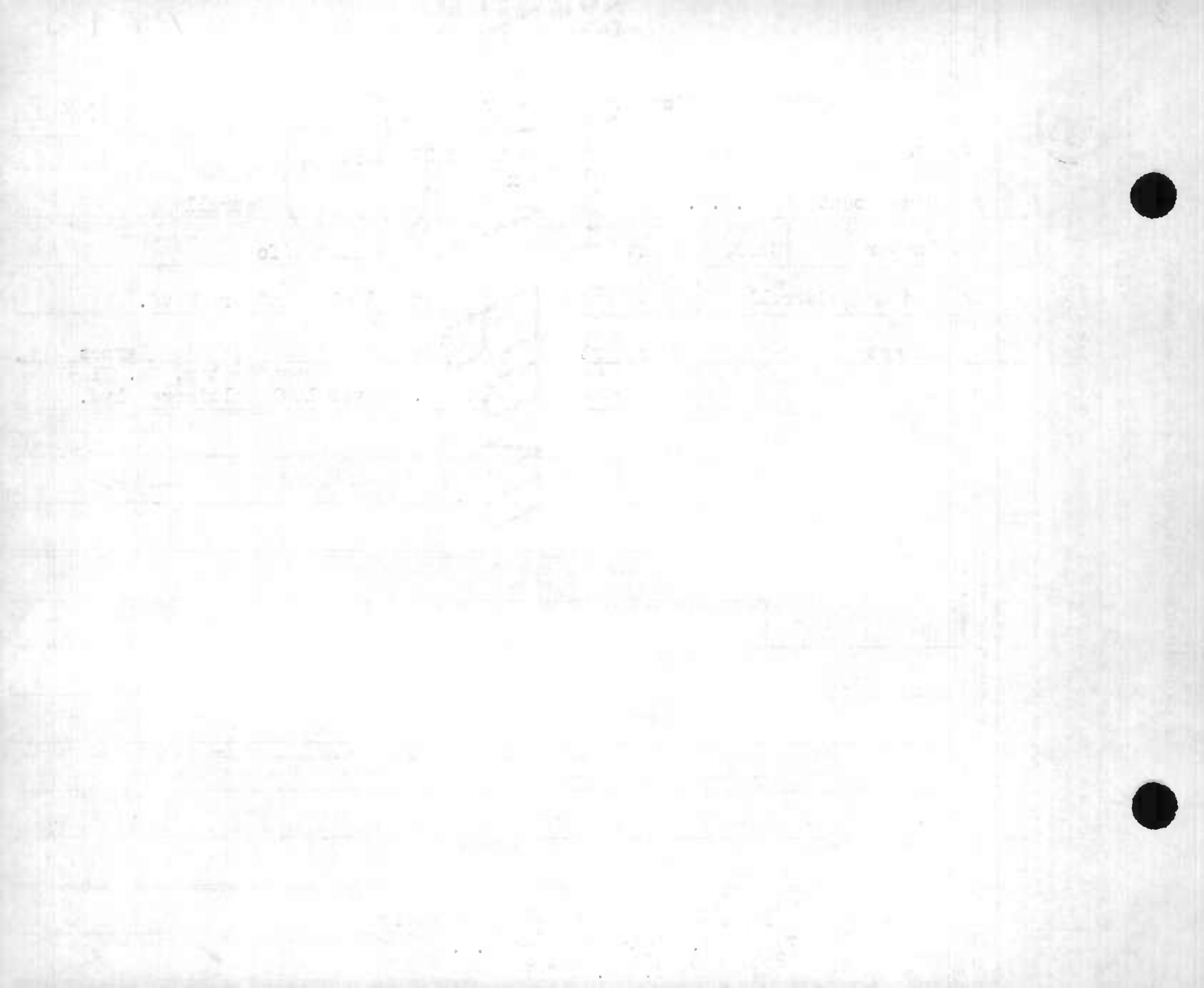


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| | | | | | |
|---|--|--|--|---|--|
| FOR 1. STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 1 0 7 7 1 0 | |
| CERTIFICATE OF DEATH | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | |
| Susan Elizabeth Farver | | | | 3-10-81 1305 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR 8. IF UNDER 24 HRS | |
| Female | | White | | 8 MONTH 2 DAY 1921 59 YRS. MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Frederick County | | U.S.A. | | Carroll MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY | |
| Westminster | | Carroll County General Hospital | | Housewife | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE | | 13c. COUNTY 13d. CITY OR TOWN | | 13e. STREET ADDRESS | |
| Maryland | | Carroll Westminster | | 1001 Baltimore Blvd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS | |
| Albert Barnhart | | Daisey Barnes | | No | |
| | | | | Westminster, Md. 21157 | |
| | | | | Roland F. Farver 1001 Baltimore Blvd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3030 Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) 4 days 3 years | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES NO 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-6-1981, to 3-10-1981, that (I) (we) last saw the deceased alive on 3-10-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Chitrachedu Naganma MD | | DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN | | 22c. DATE SIGNED 3/10/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA | | 22e. ADDRESS 174 E. Main ST WESTMINSTER MD 21157 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/14/81 | | 23c. NAME OF CEMETERY OR CREMATORY Taylorsville Cemetery | |
| 24. FUNERAL DIRECTOR NAME Del. Fletcher | | 24b. DATE REC'D. BY REGISTRAR 3/16/81 | | 25b. REGISTRAR'S SIGNATURE | |
| Thomas D. Fletcher & Son F.H. 250 East Main Street Westminster, Md. 21157 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

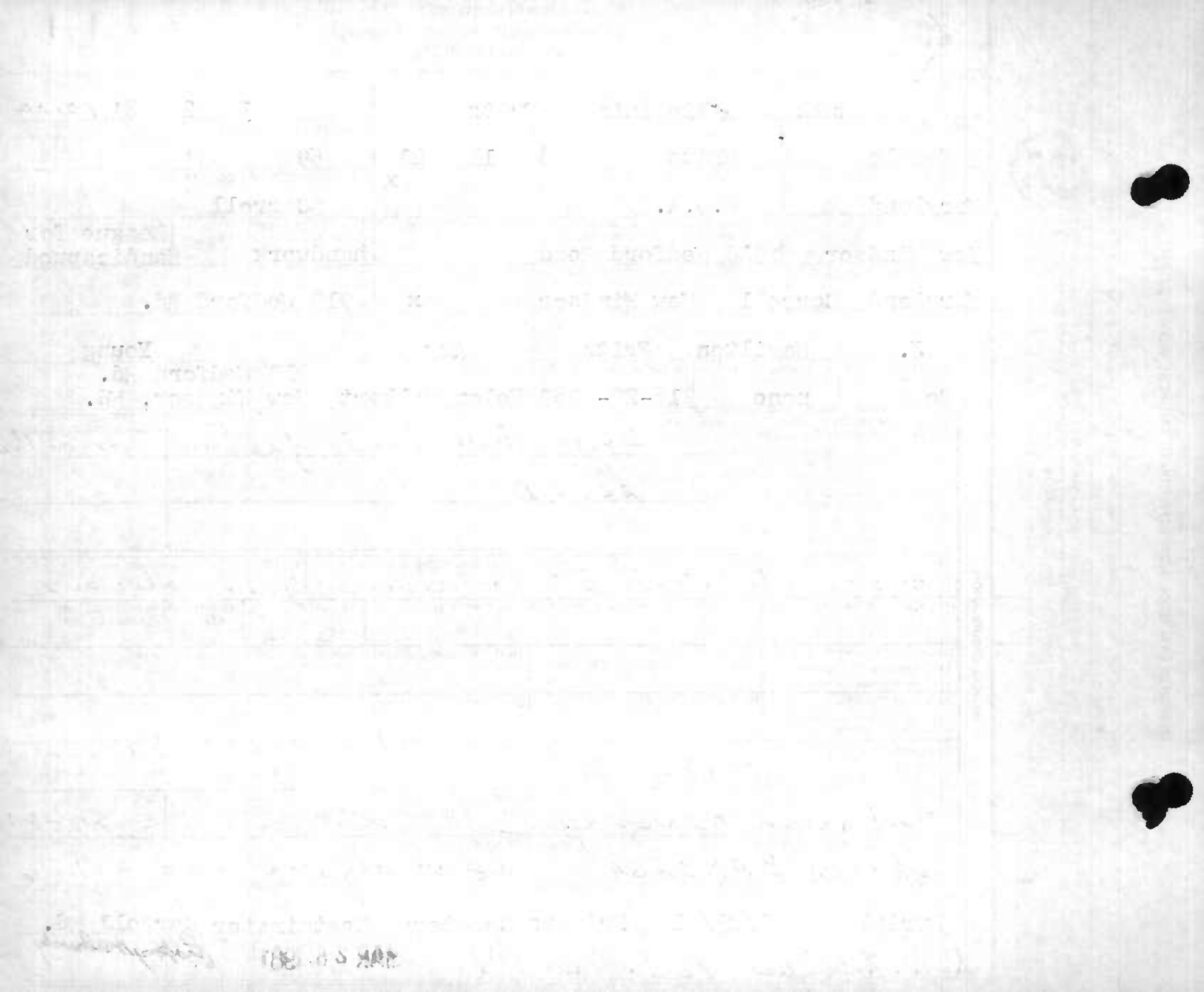
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruth Virginia Fritz | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 20 81 | | | 2b. HOUR 10:00 PM | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 11 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD. | | | | |
| 10. CITY OR TOWN OF DEATH New Windsor | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 910 Medford Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) handwork | | 12b. KIND OF BUSINESS OR INDUSTRY League for Handicapped | | |
| 13a. STATE Maryland | | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN New Windsor | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 910 Medford Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. Hamilton Fritz | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Young | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none | |
| 17. INFORMANT Helen Talbert | | | 910 Medford Rd. New Windsor, Md. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Hypoventilation 2° To severe Kyphoscoliosis</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> 19 <u>81</u> , to <u>3-20</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3-18</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Ephraim Barzaga | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3-20-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ephraim BARZAGA | | | | | | 22e. ADDRESS NEW WINDSOR, Md. 21776 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 3/23/81 | | 23c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md. | | | |
| 24. FUNERAL DIRECTOR NAME N. N. Harbler | | | | | | ADDRESS New Windsor, Md. | | 25a. DATE REC'D. BY REGISTRAR MAR 26 1981 | | |

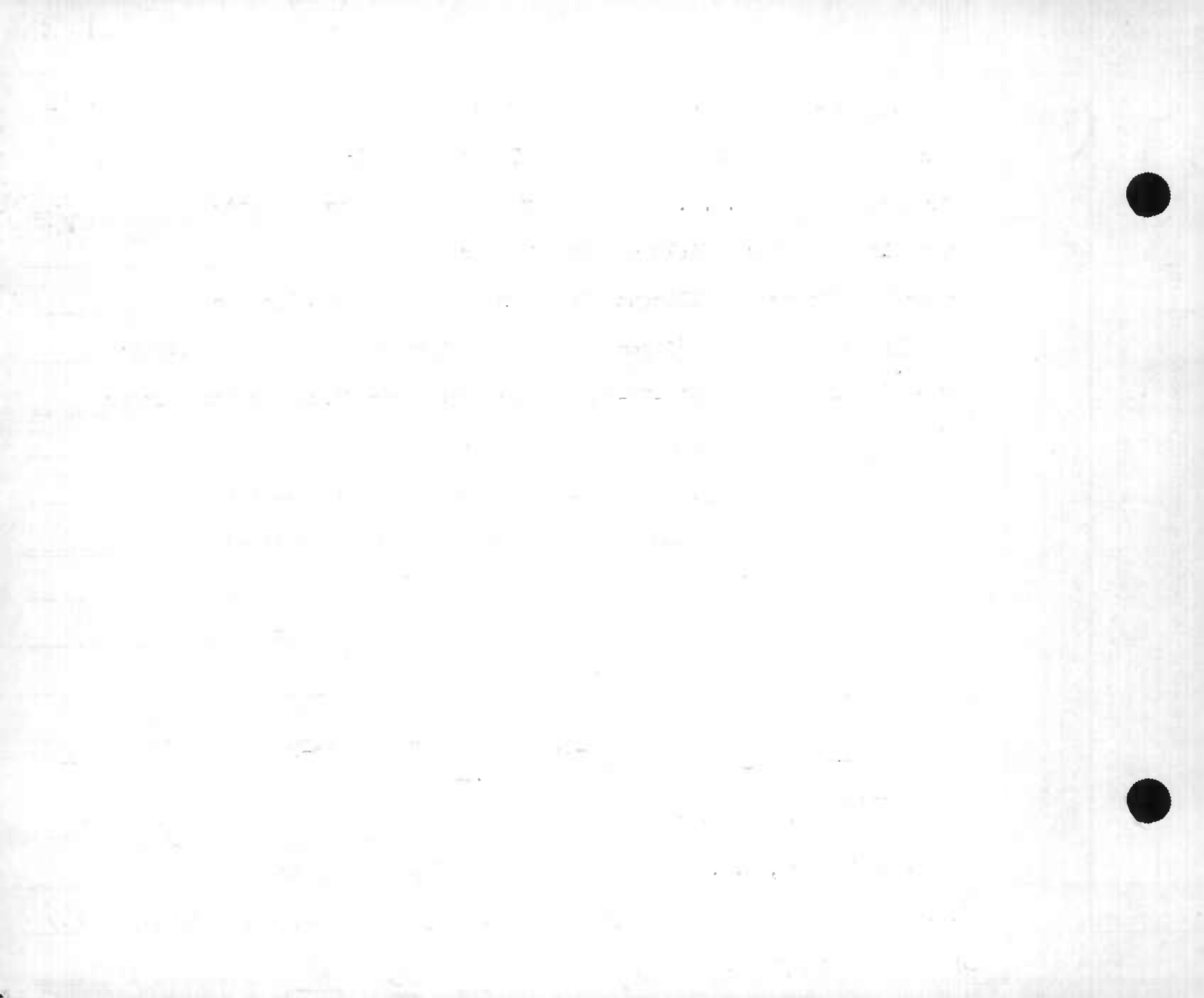


3
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 7 7 1 2 | | | |
|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Charles M. Gibson | | | 2a. DATE OF DEATH MONTH 3 DAY 9 YEAR 81 | | | 2b. HOUR 4:30 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 07 DAY 03 YEAR 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD. | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Ellicott City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE Gibson LAST Gibson | | 15. MOTHER'S MAIDEN NAME FIRST Eleanor MIDDLE Barrett LAST Barrett | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | |
| 16b. SOCIAL SECURITY NO. 579-73-3146 | | 17. INFORMANT ADDRESS Records: Springfield Hospital Center | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Pneumonia 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive Pulmonary disease | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-29 , 19 79 , to 03-09 , 19 81 , that (I) (we) last saw the deceased alive on 03-09 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jae M. Park | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3-9-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jae M. Park, M.D. | | 22e. ADDRESS Springfield Hospital Center Sykesville, MD 21784 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-11-81 | | 23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery | | 23d. LOCATION CITY OR TOWN Sykesville COUNTY Carroll STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Harry W. Haight ADDRESS Sykesville, Md. | | 25a. DATE REC'D. BY REGISTRAR MAR 12 1981 | | 25b. REGISTRAR'S SIGNATURE Harry W. Haight | | | |



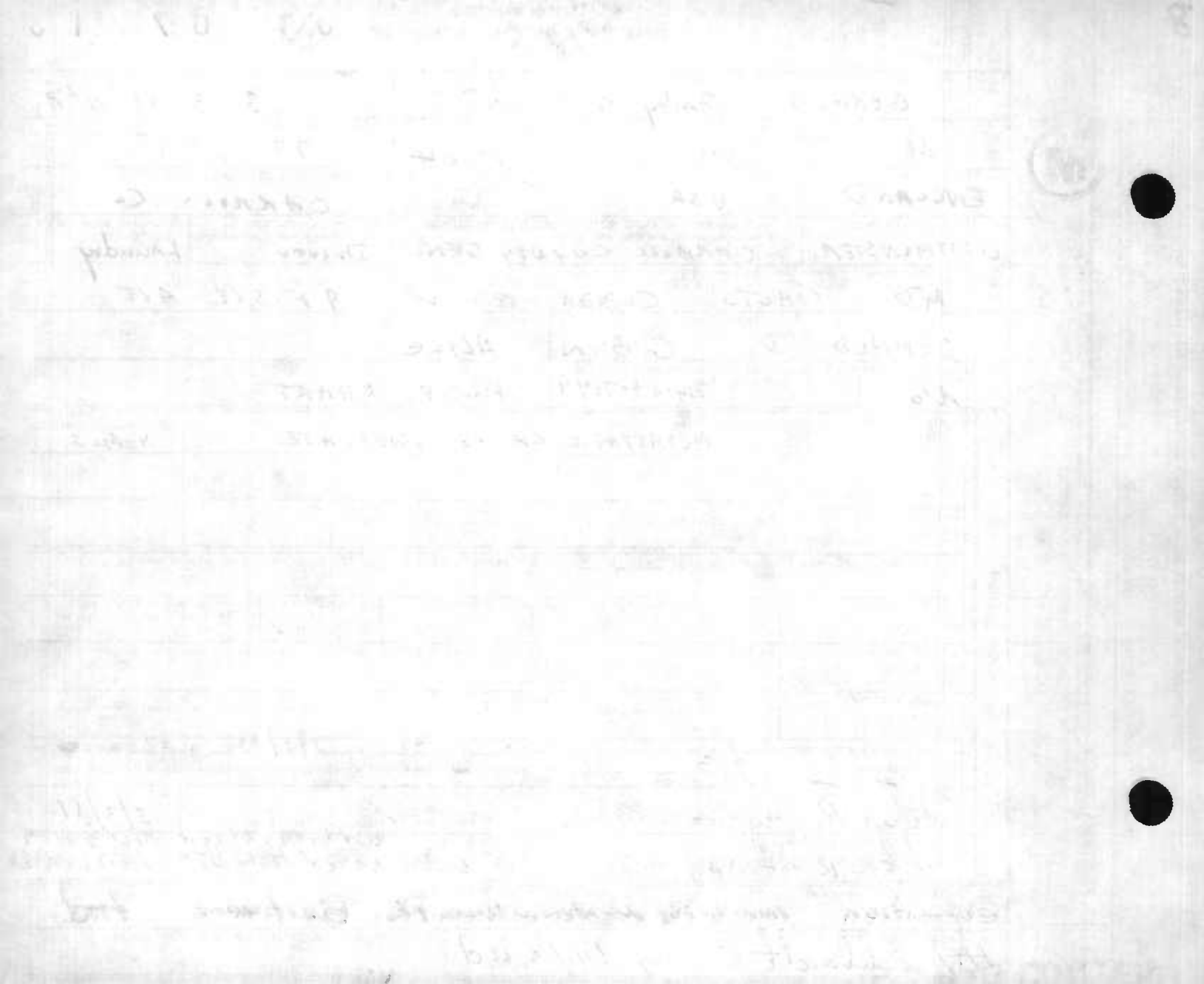
TO HOSPITAL/CLINIC ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 81 07713 | | | |
|---|--|--|--|---|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) GERALD Stanley GIBSON | | | | | 2a. DATE OF DEATH MONTH 3 DAY 3 YEAR 81 | | | |
| 3 SEX M | | 4 RACE W | | 5 DATE OF BIRTH MONTH 1 DAY 17 YEAR 04 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | 2b. HOUR 11:25 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CANNON Co. MD. | | |
| 10 CITY OR TOWN OF DEATH WESTMINSTER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CANNON COUNTY GENL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Laundry |
| 13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN GLYNDEN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 9 FISKE AVE | |
| 14 FATHER'S NAME FIRST GERALD MIDDLE D. LAST GIBSON | | | | | 15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 214-03-7049 | | 17. INFORMANT ADDRESS HOSP. CHART | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1850 METASTATIC CA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MO S |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 19 81 to 3/3/81 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 3/3 19 81 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Meyer R. Heyman MD. DEGREE MD. | | | | 22c. DATE SIGNED 3/3/81 | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEYER R. HEYMAN MD. | | | | 22e. ADDRESS 215 WASHINGTON HEIGHTS MED CENTER WESTMINSTER MD 21157 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE MAR. 4, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Ind. | | |
| 24. FUNERAL DIRECTOR NAME H. E. Schaubert ADDRESS Owings Mills, Ind. | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE MARGIE | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

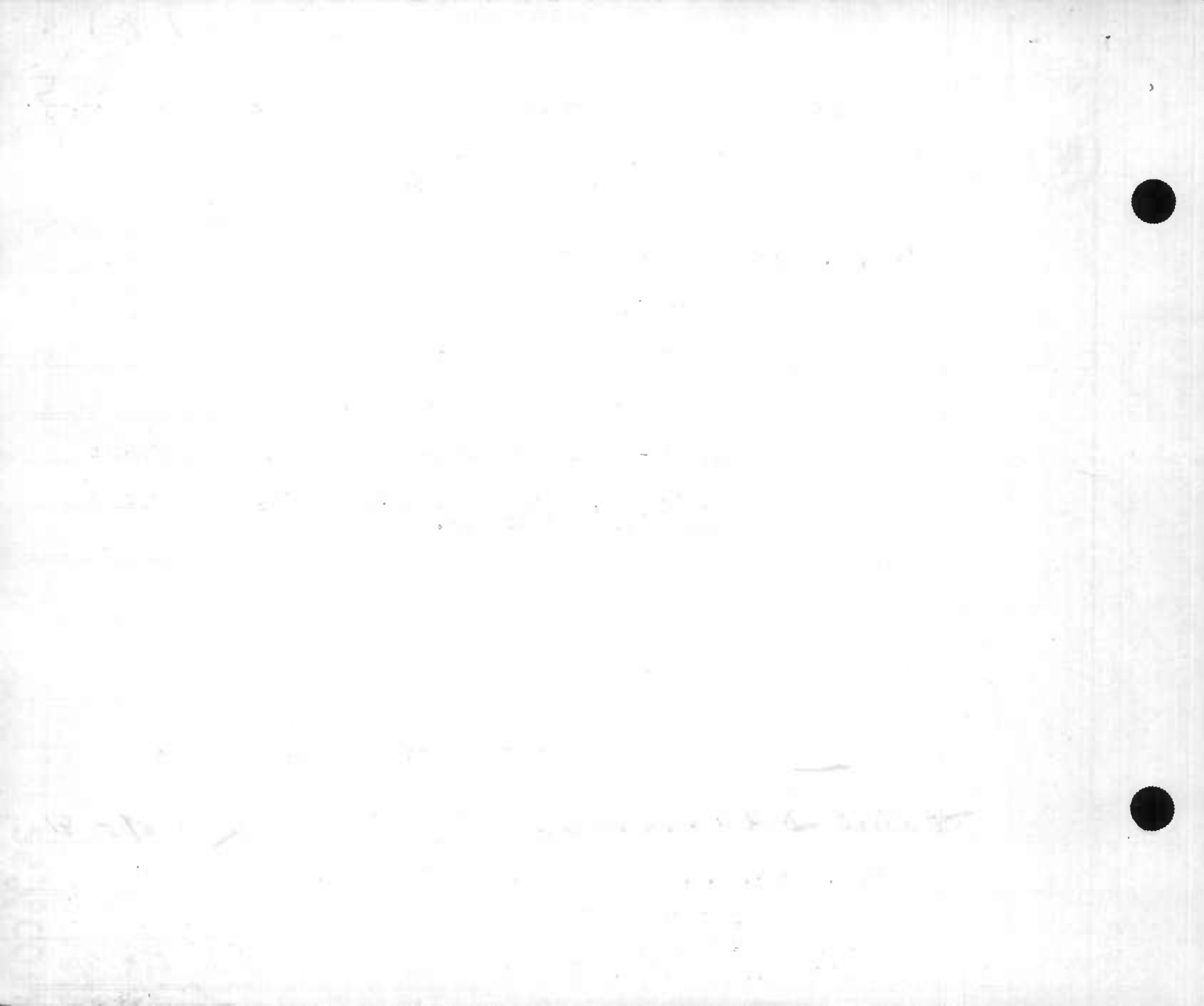
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 7 7 1 4

| FOR STATE REGISTRAR | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha Givner | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 5 81 | | 2b. HOUR 10:30 P.M. | |
| 3. SEX Female | | 4. RACE Jewish WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 6 1 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH Sykesville, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES LADY | | 12b. KIND OF BUSINESS OR INDUSTRY RETAIL | |
| 13a. STATE MARYLAND | | 13c. CITY OR TOWN PHOENIX | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2 WINDEMERE PARKWAY 21131 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MOSES GIVNER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH HETTLEMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-54-6292 | | 17. INFORMANT ALLAN GIVNER 2 WINDEMERE PKWY. PHOENIX, MD 21131 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aspiration, confluent bronchopneumonia, extensive of right lung. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 5 , 19 39 , to March 5 , 19 81 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 27b. SIGNATURE Strahil D. Nacev | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 27c. DATE SIGNED 3/5/81 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) Strahil D. Nacev, M.D. | | | | 27e. ADDRESS SPRINGFIELD HOSP. CENTER - SYKESVILLE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE MAR. 8, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | | 23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR MAR 11 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 7 1 5 | |
|--|--|---|---|--|--|
| FOR 1 - STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) MAYE Elizabeth GRIMES | | | 2a. DATE OF DEATH MONTH DAY YEAR March 27, 1981 | | 2b. HOUR 7 A.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1988 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | IF UNDER 1 YEAR MONTHS DAYS 4 5 IF UNDER 24 HRS. HOURS MIN. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD. | |
| 10. CITY OR TOWN OF DEATH Woodbine | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6109 Davis Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attendance Officer | | 12b. KIND OF BUSINESS OR INDUSTRY School |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | 13b. COUNTY Carroll | 13c. CITY OR TOWN Woodbine | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 6101 Davis Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles F. Grimes | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Brandenburg | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 220-36-9350 | | 17. INFORMANT ADDRESS Pa. Ray A. Grimes, Box 38, McKnightstown, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, ASHD, cardiac failure, 4140 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis (generalized) with post Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) gangrene right foot | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1970, 19, to 3-24-81, 19, that (I) (we) last saw the deceased alive on 3-24-81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Howard E. Hall | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3-27-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard E. Hall, M.D. | | 22e. ADDRESS PO Box 318 Sykesville, Md. 21784 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-29-1981 | 23c. NAME OF CEMETERY OR CREMATORY Taylorsville | | 23d. LOCATION CITY OR TOWN COUNTY STATE Taylorsville, Carroll, Md. |
| 24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md. | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

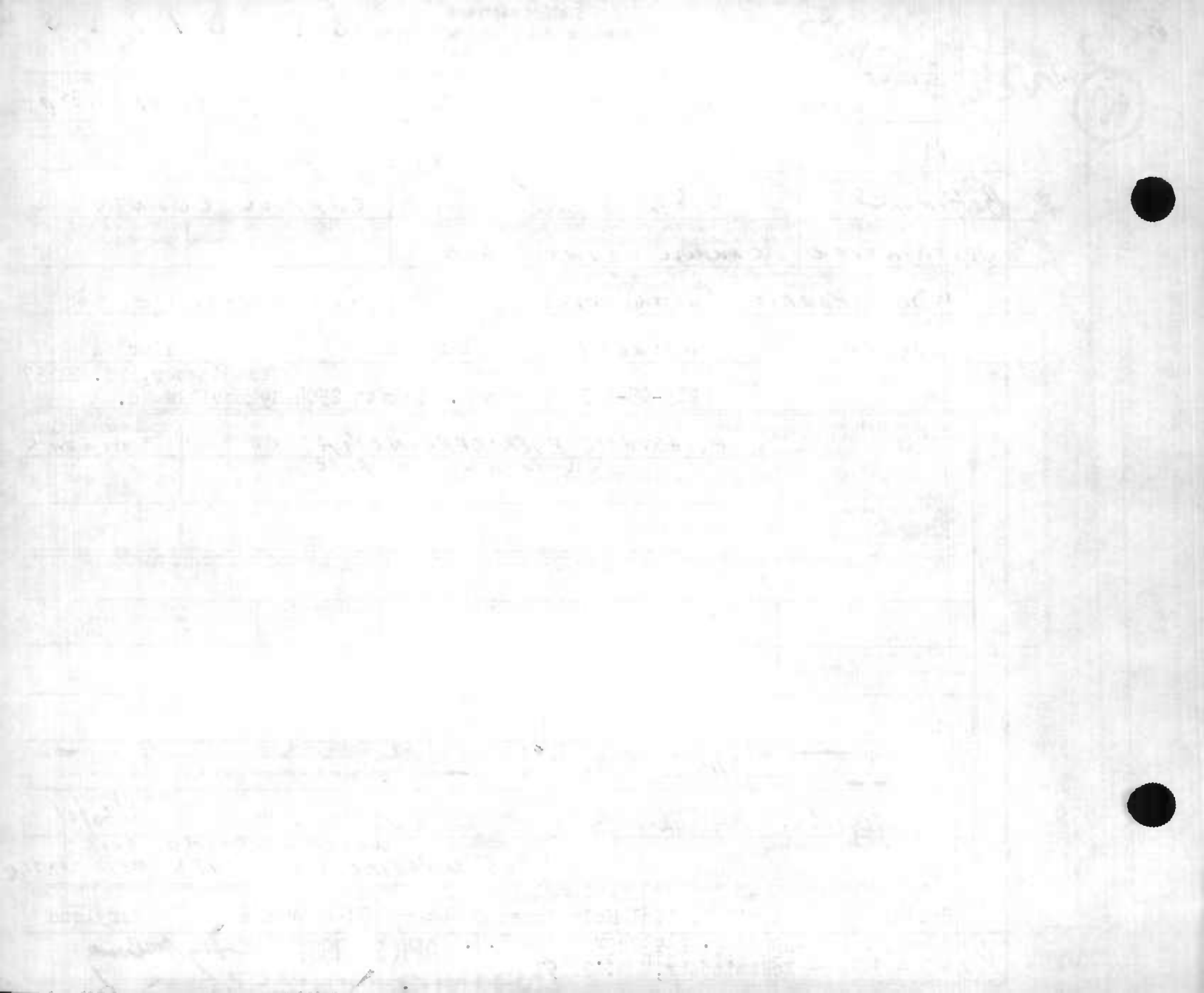
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER Joseph HACKETT Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 29 81 | | | 2b. HOUR 11 35 P.M. | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 3 16 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH WESTMINSTER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GEN | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN WESTMINSTER | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13r. STREET ADDRESS 2504 SYKESVILLE RD. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WALTER HACKETT | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Tiernan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-05-5338 | | 17. INFORMANT ADDRESS Westminster, Md. 21157 Anna N. Hackett 2504 Sykesville Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1991 METASTATIC ADENOCARCINOMA OF UNCEAIN TO SITE DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/19/81 to 3/15/81, that (I) (the hospital) saw the deceased alive on 3/19/81, and that in (my) (the hospital) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Meyer R. Heyman M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 3/30/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEYER R. HEYMAN M.D. | | | | 22e. ADDRESS WESTMINSTER MD 21157 215 WASHINGTON HEIGHTS MED CENTER | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE April 1, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H. 254 East Main St. Westminster, Md. 21157 | | APR 3 1981 | | REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

MEDICAL CERTIFICATION

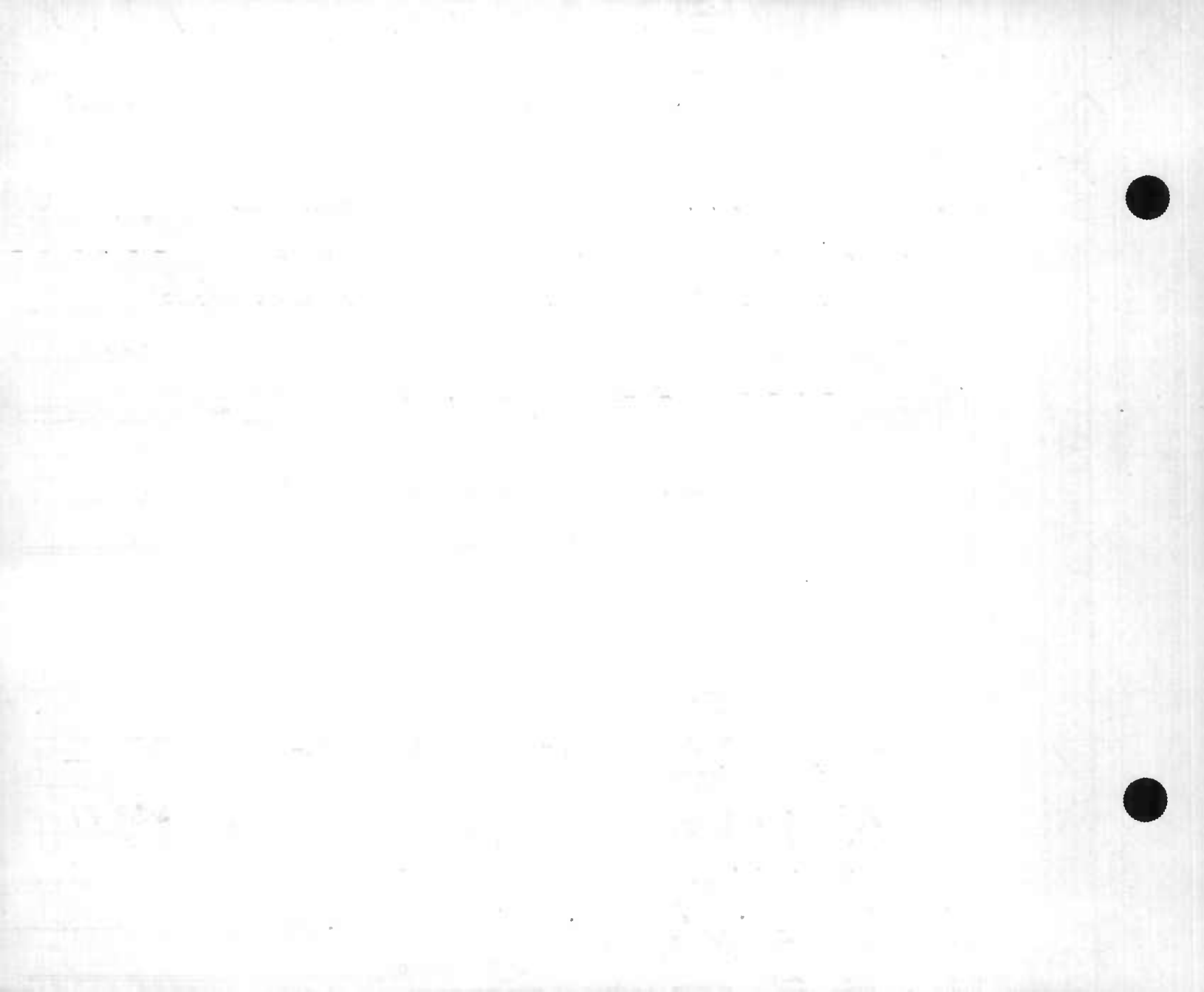


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 0 7 7 1 7 | |
|--|--|---|---|---|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) George R. Hanes | | | 2a. DATE OF DEATH MONTH DAY YEAR 03 23 81 | | | 2b. HOUR 7:30 | | | A M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 04 03 94 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 24 HRS HOURS MIN. MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad | | 12b. KIND OF BUSINESS OR INDUSTRY - - - - - | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Frederick | | | 13c. CITY OR TOWN Point of Rocks | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS no street address | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Hanes | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lowry | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-12-1766 | | | 17. INFORMANT ADDRESS Records, Springfield Hospital Center | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | |
| 4039 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriolar nephrosclerosis | | | | | | | | | | years | |
| (c) Generalized arteriosclerosis | | | | | | | | | | years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-27 , 19 38 , to 03-23 , 19 81 , that (I) (we) last saw the deceased alive on 03-23 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Else Hillgard</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 3-23-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Else Hillgard, M.D. | | | 22e. ADDRESS Springfield Hospital Center Sykesville, MD 21784 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Mar. 25, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pt. of Rocks Frederick Md | | | | |
| 24. FUNERAL DIRECTOR Smith Padeley | | | ADDRESS Keeney Bassford Funeral Home | | | 25. DATE REC'D. BY REGISTRAR MAR 27 1981 | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |



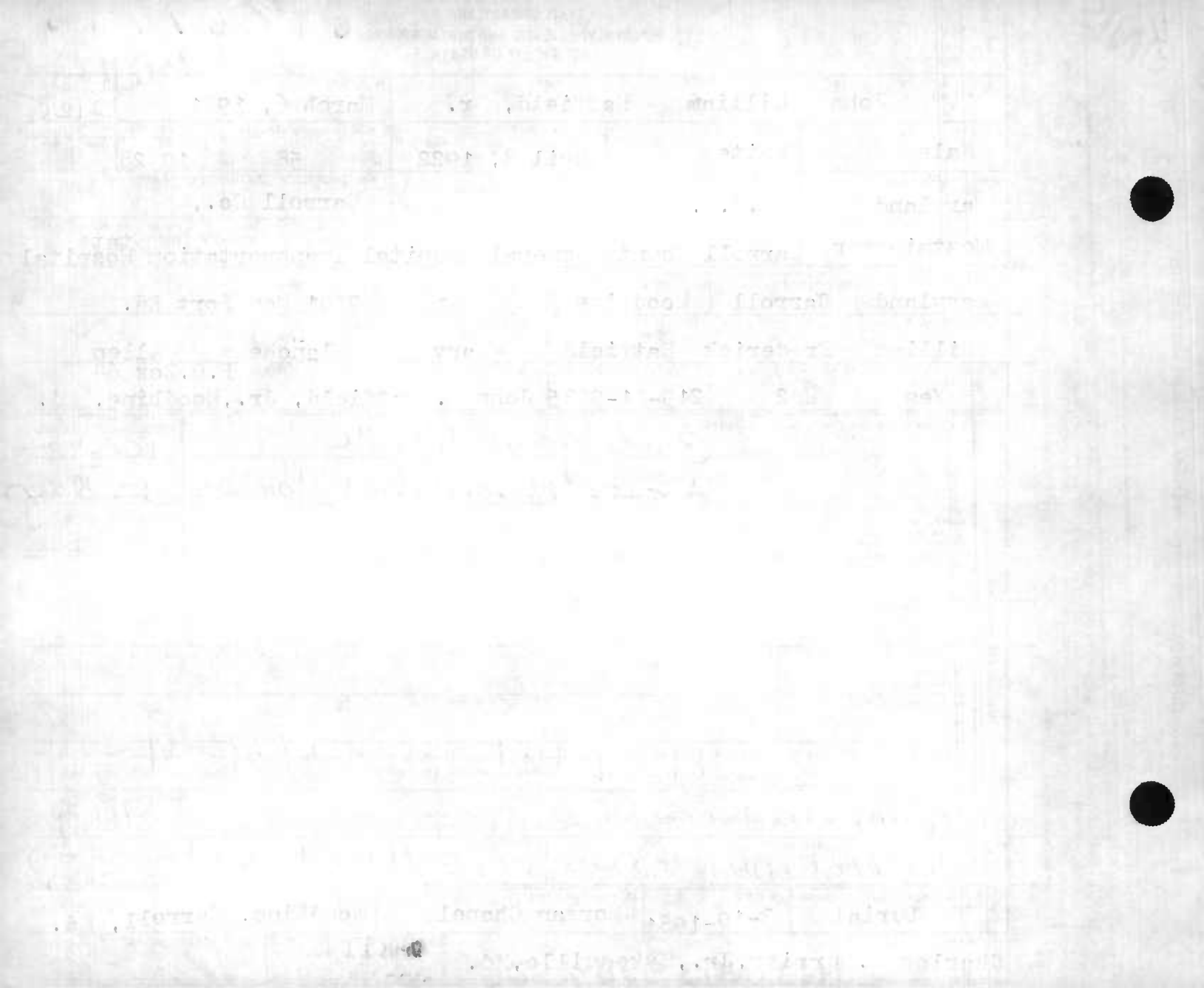
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH MONTH DAY YEAR | | 2b HOUR | |
| John William Hatfield, Sr. | | | | | | | | March 6, 1981 | | 2125M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS (LAST BIRTHDAY)) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| Male | | White | | April 8, 1922 | | 58 YRS | | 10 28 | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Carroll Co., MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Westminster | | Carroll County General Hospital | | | | | | Transportation Hospital | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b STATE | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | |
| Maryland | | Carroll | | Woodbine | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7501 New Port Rd. | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| William Frederick Hatfield | | Mary Blanche Allen | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | | | |
| Yes | | WW 2 | | 219-01-9735 | | John W. Hatfield, Jr., Woodbine, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4100 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial infarction</u> | | | | | | | | | | 10 1/2 hours | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | 19 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3/6/81</u> to <u>3/6/81</u> , that (I) (we) last saw the deceased alive on <u>3/6/81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | | | | | 22c DATE SIGNED | | | |
| <u>Chitra Chedunaganna MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 3/6/81 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | |
| CHITRA CHEDUNAGANNA | | 174 E Main St Westminster MD 21157 | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 3-10-1981 | | Morgan Chapel | | Woodbine, Carroll, Md. | | | | | |
| 24 FUNERAL DIRECTOR NAME | | 25a DATE REC'D BY REGISTRAR | | | | | | 25b REGISTRAR'S SIGNATURE | | | |
| Charles W. Burrier, Jr., Sykesville, Md. | | APR 11 1981 | | | | | | | | | |

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TO HOSPITAL-RETAIN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 7 1 0 7 7 1 9 | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAE P. Hollenberry | | | 2a. DATE OF DEATH MONTH DAY YEAR 3-1-81 | | 2b. HOUR 1821 M |
| 3 SEX Female | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR April 28, 1907 | 6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD. | | |
| 10. CITY OR TOWN OF DEATH Westminster | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL Co. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 13a. STATE Md. 13b. COUNTY CARROLL 13c. CITY OR TOWN Sykesville | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Obrecht Rd. |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nimrod Phillips | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Gardner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO ? | | 17. INFORMANT ADDRESS Grant Hollenberry Sykesville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive Heart failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Chitrachedu Nagananna | | DEGREE MD | | 22c. DATE SIGNED 3/1/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA | | 22e. ADDRESS 1745 Main St Westminster MD 21157 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 3-5-81 | | 23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery | |
| 23d. LOCATION CITY OR TOWN Sykesville | | COUNTY Carroll | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Harry W. Haight | | ADDRESS Sykesville, Md. | | 25a. DATE REC'D. BY REGISTRAR 3/5/81 | |
| | | 25b. REGISTRAR'S SIGNATURE | | | |



[Faint, illegible handwriting on lined paper]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

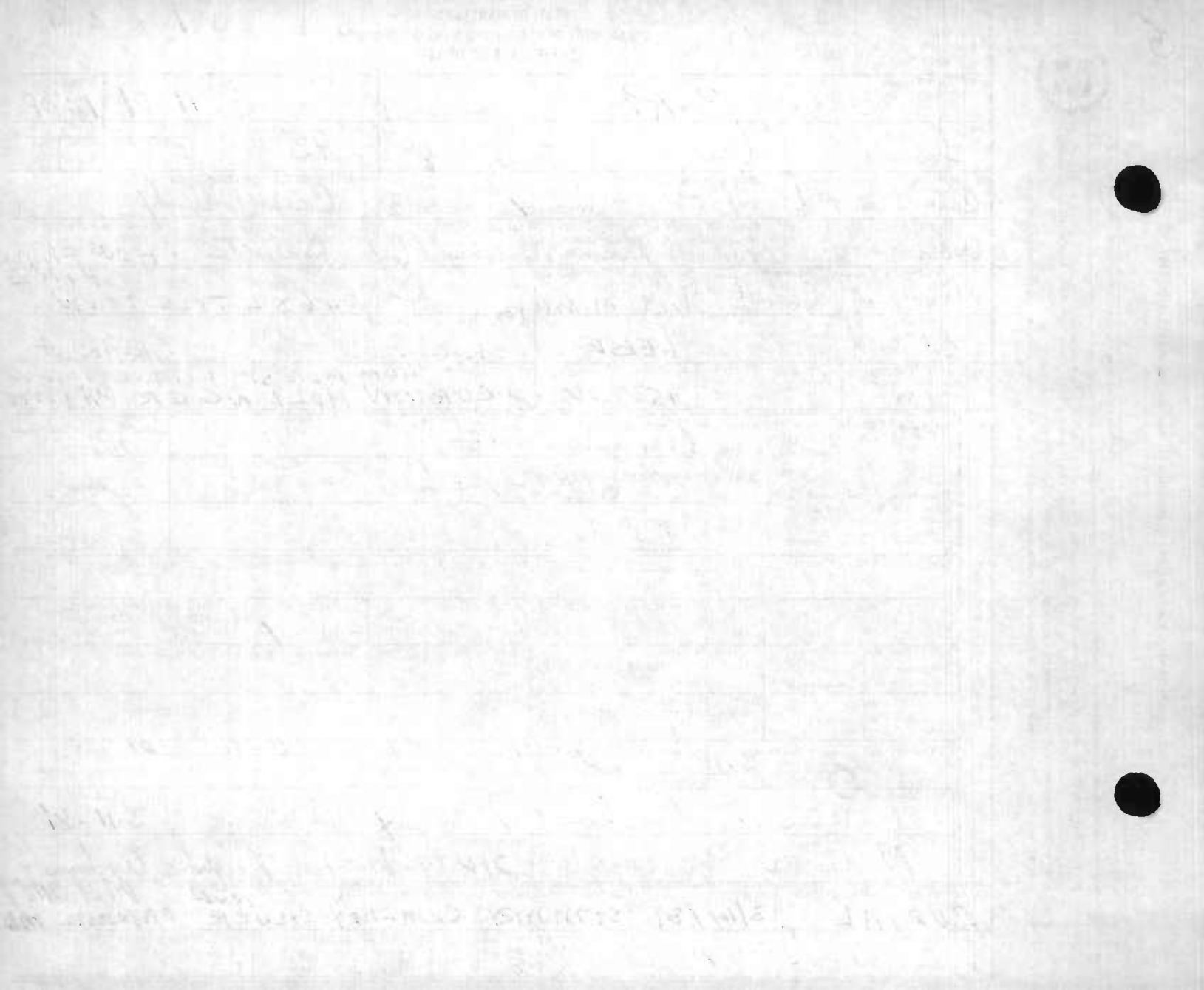
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MONTH DAY YEAR | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. MONTHS DAYS HOURS MIN | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. INJURY OCCURRED | | 21g. PLACE OF INJURY | | 21h. LOCATION | | 21i. CITY OR TOWN | | 21j. COUNTY | |
| 21k. STATE | | 21l. I certify that (I) (this hospital) attended the deceased from <u>6-19</u> , 19 <u>74</u> , to <u>3-11</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3-11</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22a. SIGNATURE | | 22b. ADDRESS | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. NAME OF CEMETERY OR CREMATORY | | 22g. LOCATION | | 22h. CITY OR TOWN | |
| 22i. STATE | | 22j. COUNTY | | 22k. DATE REC'D. BY REGISTRAR | | 22l. REGISTRAR'S SIGNATURE | | 22m. DATE OF DEATH | |
| 22n. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 22o. DATE | | 22p. NAME OF CEMETERY OR CREMATORY | | 22q. LOCATION | | 22r. CITY OR TOWN | |
| 22s. STATE | | 22t. COUNTY | | 22u. DATE REC'D. BY REGISTRAR | | 22v. REGISTRAR'S SIGNATURE | | 22w. DATE OF DEATH | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | |
|---|------------------------|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Florence Helen Hyde | | 2a. DATE KNOWN OF DEATH ESTIMATED 3 29 1981 | | 2b. HOUR 5:45 P.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 9 11 1898 | 6. AGE (IN YEARS) ST BIRTHDAY YRS 82 | 7c. DATE PRONOUNCED DEAD 3 29 1981 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Middleburg, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY |
| 13. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD | | | | |
| 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE Maryland | 13b. COUNTY Carroll | 13c. CITY OR TOWN Westminster | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 1732 Bethel Road |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Hubbs | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Susanna Wilson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-26-1783 | | 17. INFORMANT ADDRESS Helen M. Bosley 1732 Bethel Rd Westminster, Md. 21157 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Green Negative Septicemia</u> 8159 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Multiple traumatic injuries</u> 6 Wks (c) <u>Auto Accident One Car</u> 6 Wks | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION 14 Feb 81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture Femur & Patella | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:22 AM 11 Feb 1981 | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto Accident One Car Street Pole | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road | | 21f. LOCATION CITY OR TOWN COUNTY STATE Route #97, Near Silver Run Road | | |
| 22a. I certify that I took charge of the remains described above, held in Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE Richard C. Jones | | TITLE (SPECIFY) Deputy | | DATE SIGNED 30 Mar 81 |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 4/2.81 | 23c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Maryland |
| 24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H. 251 East Main St. Westminster, Md. 21157 | | 25a. DATE REC'D. BY REGISTRAR APR 3 1981 | | 25b. REGISTRAR'S SIGNATURE Dorothy McCreedy |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 07122

REG. NO.

| | | | | | | | | | |
|--|--|--|---|--|---|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) IDA MAY JACOBS | | | 2a DATE OF DEATH MONTH DAY YEAR 3 21 81 | | | 2b HOUR 07 48 | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 05 04 86 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD. | | | |
| 10 CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Hospital | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a STATE Md. | | | 13b COUNTY Carroll | | 13c CITY OR TOWN Sykesville | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Alvin Harris | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Smaller | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219.34 4492 | | 17 INFORMANT ADDRESS Wm Creever Sykesville, Md. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hour | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) diabetes mellitus; gangrene - right foot - large ulcers - hip | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3-20 , 19 80 , to 3-21 , 19 81 , that (I) (we) last saw the deceased alive on 3-20 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Ephraim Barzaga | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 3-21-81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) EPHRAIM BARZAGA | | | | | | 22e ADDRESS NEW WINDSOR Md. 21776 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 3-23-81 | | 23c NAME OF CEMETERY OR CREMATORY Springfield Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md. | | |
| 24 FUNERAL DIRECTOR NAME Harry W. Haight | | | ADDRESS Sykesville, Md. | | | 25 MARYLAND REGISTRAR Harry W. Haight | | 26 REGISTRAR'S SIGNATURE Harry W. Haight | |

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[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1- STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8107123 | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Otto J. F. Jade | | | | 2a DATE OF DEATH MONTH DAY YEAR 03 06 81 | | | | 2b HOUR 0147 M | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 04 12 96 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD | | | | | |
| 10 CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a STATE MD | | 13b COUNTY Carroll | | 13c CITY OR TOWN Finksburg | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS Finksburg MD 1917 Suffolk Road 21048 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST - Jade | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b SOCIAL SECURITY NO 216-09-1077 | | 17 INFORMANT ADDRESS Mr. Albert Sauer same | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days Yrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from 3-2 , 19 81 , to 3-6 , 19 81 , tho (1) (we) lost saw the deceased alive on 3-5 , 19 81 , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Alva S. Baker | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 3-6-81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Alva S. Baker | | | | 22e ADDRESS 218 Washington Heights Medical Center Westminster MD 21157 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b DATE Mar. 9, 1981 | | 23c NAME OF CEMETERY OR CREMATORY Parkwood | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24 FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland | | | | ADDRESS | | | | 25a DATE REC'D. BY REGISTRAR MAR 9 1981 | | 25b REGISTRAR'S SIGNATURE Alva S. Baker | |

BP _____

loc. cit. 1921, 2. 152

A.V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 7 7 2 4

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lillian Elenora Jensen | | | 2a. DATE OF DEATH MONTH DAY YEAR 3-29-81 | | 2b. HOUR 12:30 P M | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 9 5 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Iowa | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD. | | |
| 10. CITY OR TOWN OF DEATH Sykesville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Springfield Hospital Center | | | 12a. USUAL OCCUPATION (TELL WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. CITY OR TOWN Baltimore | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 3132 Berkshire Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Amos Helgason | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Olson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-03-1625 | | 17. INFORMANT ADDRESS Records, Springfield Hospital Center | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extensive Metastatic Disease 1749 DUE TO, OR AS A CONSEQUENCE OF (b) CA. of the Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-6 , 19 70 , to 3-29 , 19 81 , that (I) (we) lost saw the deceased alive on 3-29 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Octavio A. Ruiz MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3/29/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Octavio A. Ruiz MD | | 22e. ADDRESS Springfield Hosp Center Sykesville Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | 23b. DATE 3-31-81 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md. |
| 24. FUNERAL DIRECTOR NAME Harry W. Haight | | | | 24b. DATE REC'D. BY REGISTRAR APR 3 1981 | | 24c. REGISTRAR'S SIGNATURE Lillian Helgason |

BP

DHMH-16 20M
(VRA 15, 4) 7/78

10



WESTO



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

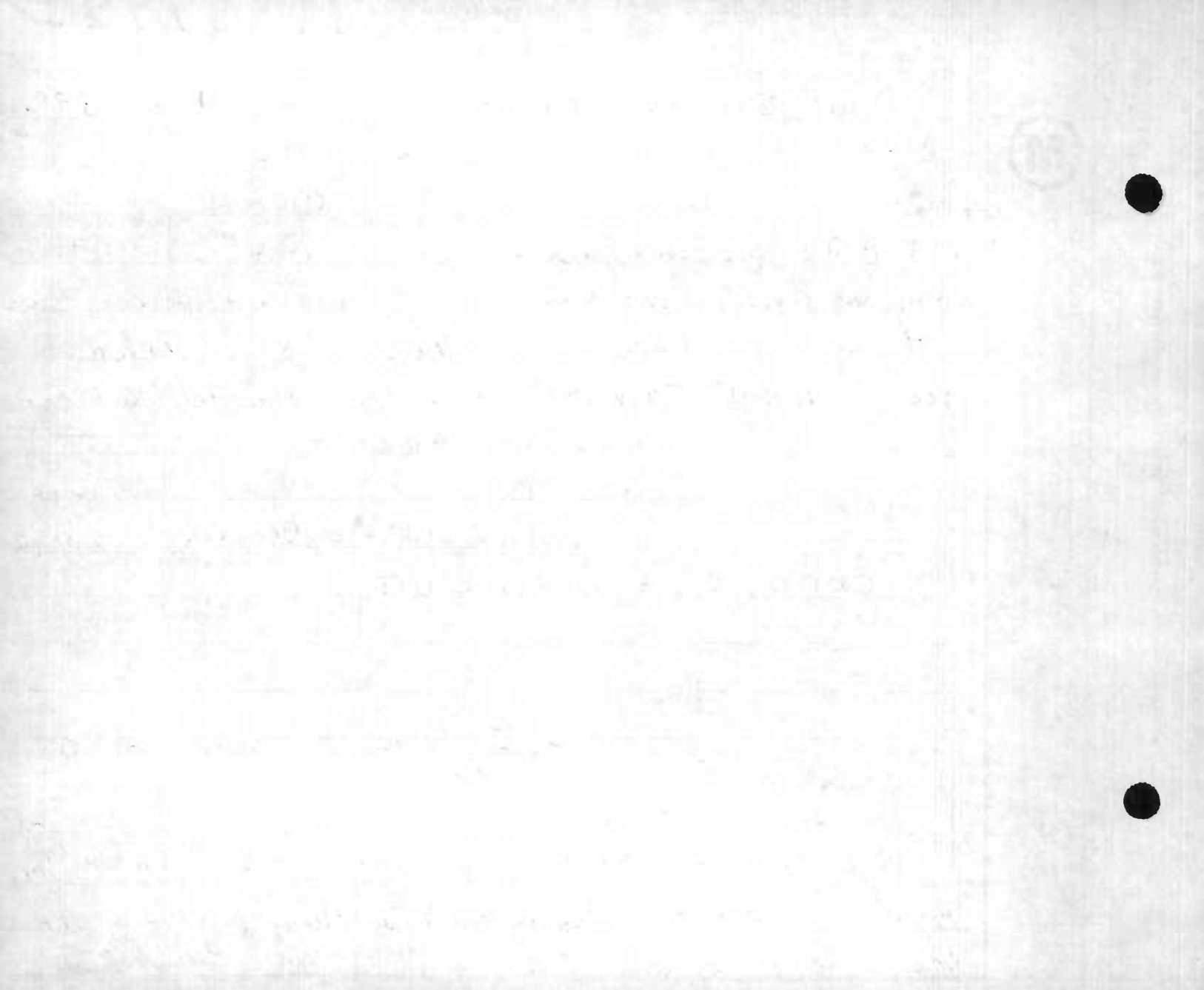
| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) PAUL EDWARD KANE | | 2a. DATE OF DEATH MONTH MARCH DAY 10 YEAR 81 | | 2b. HOUR 8:50 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 4 DAY 21 YEAR 08 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH MT AIRY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View N.H. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY Carroll | | 13c. CITY OR TOWN MT AIRY | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE W. LAST Kane | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE K. LAST March | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II | | 17. INFORMANT Charles Kane - Oxon Hill, Md. 20022 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCUD DUE TO, OR AS A CONSEQUENCE OF (c) General Atherosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEC > 104R > 104R |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD CVA CHRONIC UTI | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/8 19 78 , to 3/10 19 81 , that (I) (we) last saw the deceased alive on 3/5 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Melvin Skender | | | | 22c. DATE SIGNED 3/11/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MELVIN KORDAN | | | | 22e. ADDRESS 2000 Century Plaza Columbia Md 21046 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-14-81 | | 23c. NAME OF CEMETERY OR CREMATORY Jefferson Mem. Cemetery | |
| 24. FUNERAL DIRECTOR NAME Harry W. Haight ADDRESS Sylgaville, Md. | | 23d. LOCATION CITY OR TOWN Pleasant Hills COUNTY Bowen STATE PA | | 25a. DATE REC'D. BY REGISTRAR MAR 12 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Esther K. Hight | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 7 / 2 6 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HARRY T. KUHNS | | | | 2a. DATE OF DEATH MONTH 3 DAY 5 YEAR 84 | | 2b. HOUR 5:45 AM | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH 6 DAY 18 YEAR 1895 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD. | |
| 10. CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen'l Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY B&D | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Hampstead | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE Kuhns LAST Rhodes | | 15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE Rhodes LAST Rhodes | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO. 213-05-1385A | | 17. INFORMANT ADDRESS Mrs. Mary T. Kuhns, Hampstead, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Anemia, HCVS - Actual Febrile | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-4 19 81 , to 3-5 19 81 , that (I) (we) lost saw the deceased alive on 3-5 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Manuel J. Sevilla | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3-5-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Manuel J. Sevilla | | 22e. ADDRESS 419 C. Walden Dr. Westminster, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-7-81 | | 23c. NAME OF CEMETERY OR CREMATORY Manchester Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md. | |
| 24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAR 10 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

3-7-1 Manchester Conn. Manchester Carroll Md.

no Mrs. Mary T. Thomas, Hampstead, Md.

Thomas Alice Kuhn

Ms. Carroll Hampstead

Westminster Carroll County Md. Hosp. Mechanist

Maryland USA Carroll Co.

White 6 115 85

HARRY T. KUHNS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|-------------------------|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>John P. Lange</i> | | | 20. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 3 21 81 <input type="checkbox"/> 3 21 81 | | |
| 3. SEX <i>M</i> | 4. RACE <i>white</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>June 28 1902</i> | 6. AGE (IN YEARS) (LAST BIRTHDAY) <i>78</i> YRS. | 7. IF UNDER 24 HRS. HOURS MINUTES SECONDS | 21. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>3 21 1981</i> |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7c. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH <i>Westminster</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>617 E. Deep Run Road</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Railroad</i> | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Carroll</i> | | 13c. CITY OR TOWN <i>Westminster</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John ? Lange</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Charlotte ? Pfeiffer</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i> | |
| 16b. SOCIAL SECURITY NO. <i>705-10-7238</i> | | 17. INFORMANT <i>Ruby Lange</i> | | 17. ADDRESS <i>617 E. Deep Run Rd. Westminster, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Neurovascular Cardiovascular Disease</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Suspected bilateral lower leg amputations</i> (c) <i>part 3 yrs.</i> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE <i>Richard A. Jones</i> | | TITLE (SPECIFY) <i>Deputy</i> | | DATE SIGNED <i>21 Mar 81</i> | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>RICHARD A. JONES</i> | | ADDRESS <i>WESTMINSTER, MD. 21159</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>3/24/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial</i> | |
| 24. FUNERAL DIRECTOR NAME <i>H. F. Eckhardt</i> | | ADDRESS <i>Manchester, Md.</i> | | 25a. DATE REG'D. BY REGISTRAR <i>MAR 21 1981</i> | |
| 23d. LOCATION CITY OR TOWN <i>Balt.</i> | | COUNTY <i>Md.</i> | | STATE <i>Md.</i> | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) VIRGINIA LEE MARTIN | | 2a. DATE OF DEATH MONTH DAY YEAR March 26, 1981 | | 2b. HOUR 0653 M | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 10 - 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD | | 10. CITY OR TOWN OF DEATH WESTMINSTER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE KEEPER | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 13a. STREET ADDRESS 106 N MAIN ST. | |
| 13b. COUNTY MARYLAND | | 13c. CITY OR TOWN UNION BRIDGE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES B BANKARD | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIE ZEPP | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 217-36-4862 | | 17. INFORMANT ADDRESS NINA MARTIN 106 N MAIN ST. UNION BRIDGE MD | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4140 DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerosis heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from March 24, 1981 , to March 26, 1981 , that (I) (we) last saw the deceased alive on March 26, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | |
| 22b. SIGNATURE John S. Harshey, M.D. | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3/26/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, M.D. | | 22e. ADDRESS 8 anchor st. Westminster md. | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | |
| 23b. DATE MAR 28-1981 | | 23c. NAME OF CEMETERY OR CREMATORY PIPE CREEK | | 23d. LOCATION CITY OR TOWN COUNTY STATE NEW WINDSOR CARROLL MD | |
| 24. FUNERAL DIRECTOR NAME DD Hartzler | | ADDRESS Union Bridge Md | | 25a. DATE REC'D. BY REGISTRAR MAR 30 1981 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CONFIDENTIAL

JOSE COLLON



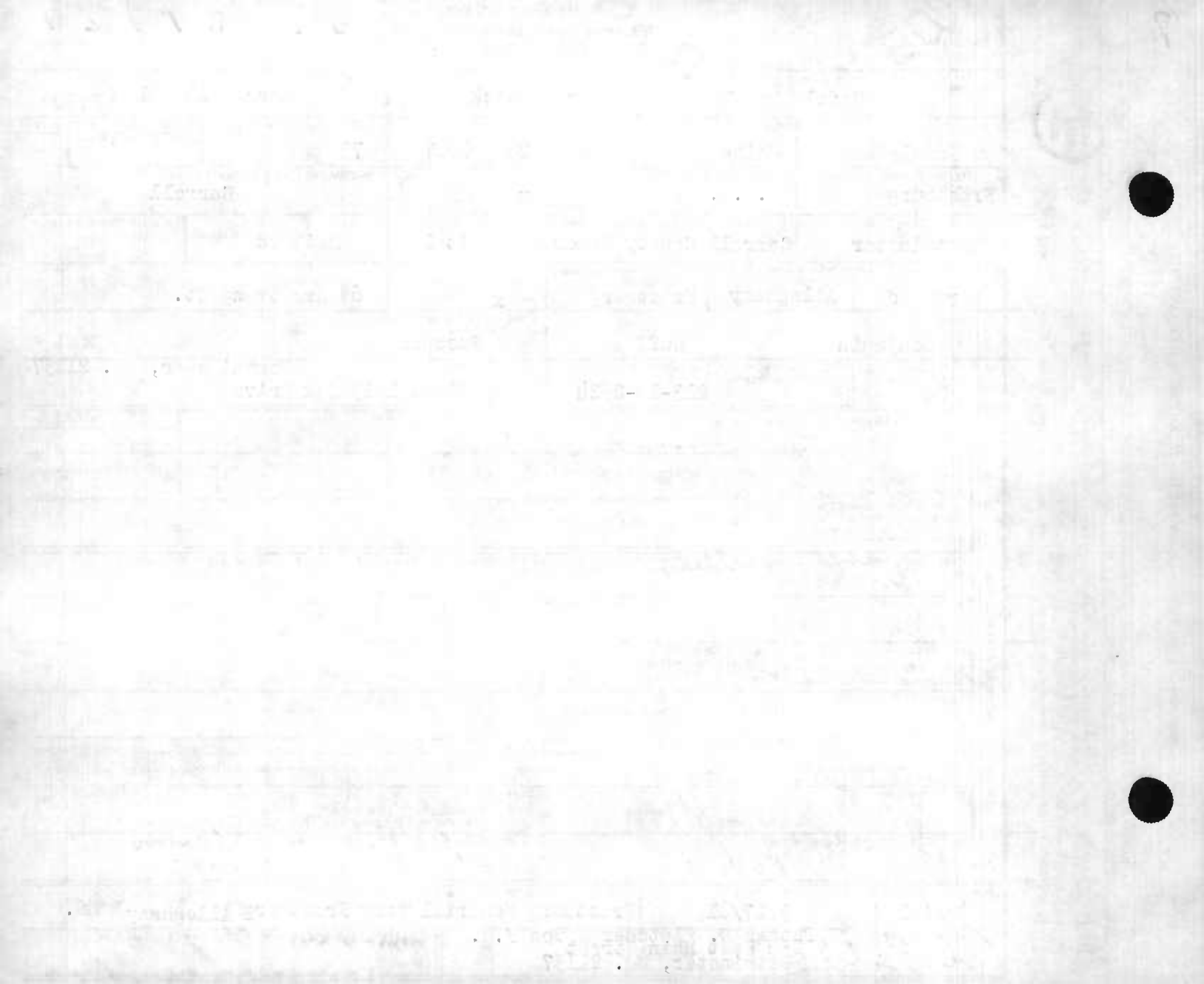
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Hazel May McClintock | | | MONTH DAY YEAR March 24 81 | | 2b. HOUR 2:30P M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 24 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frostburg | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD | | |
| 10. CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY Alleghany | | 13c. CITY OR TOWN Frostburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Huff | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susanna Deal | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO 213-18-2524 | | 17. INFORMANT Mary Kloss 1019 Oak Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/19 , 19 81 , to 3/24 , 19 81 , that (I) (we) last saw the deceased alive on 3/24 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE N. Poulson MD | | | | DEGREE MD | | 22c. DATE SIGNED 3/24/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN POULSEN | | | | 22e. ADDRESS 218 WASH HGTs MED CENTER WESTMINSTER MD. 21157 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Alleghany | | 23d. LOCATION CITY OR TOWN COUNTY STATE MD. | | |
| 24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H. | | | | 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |
| 24. ADDRESS 254 East Main Street Westminster, Md. 21157 | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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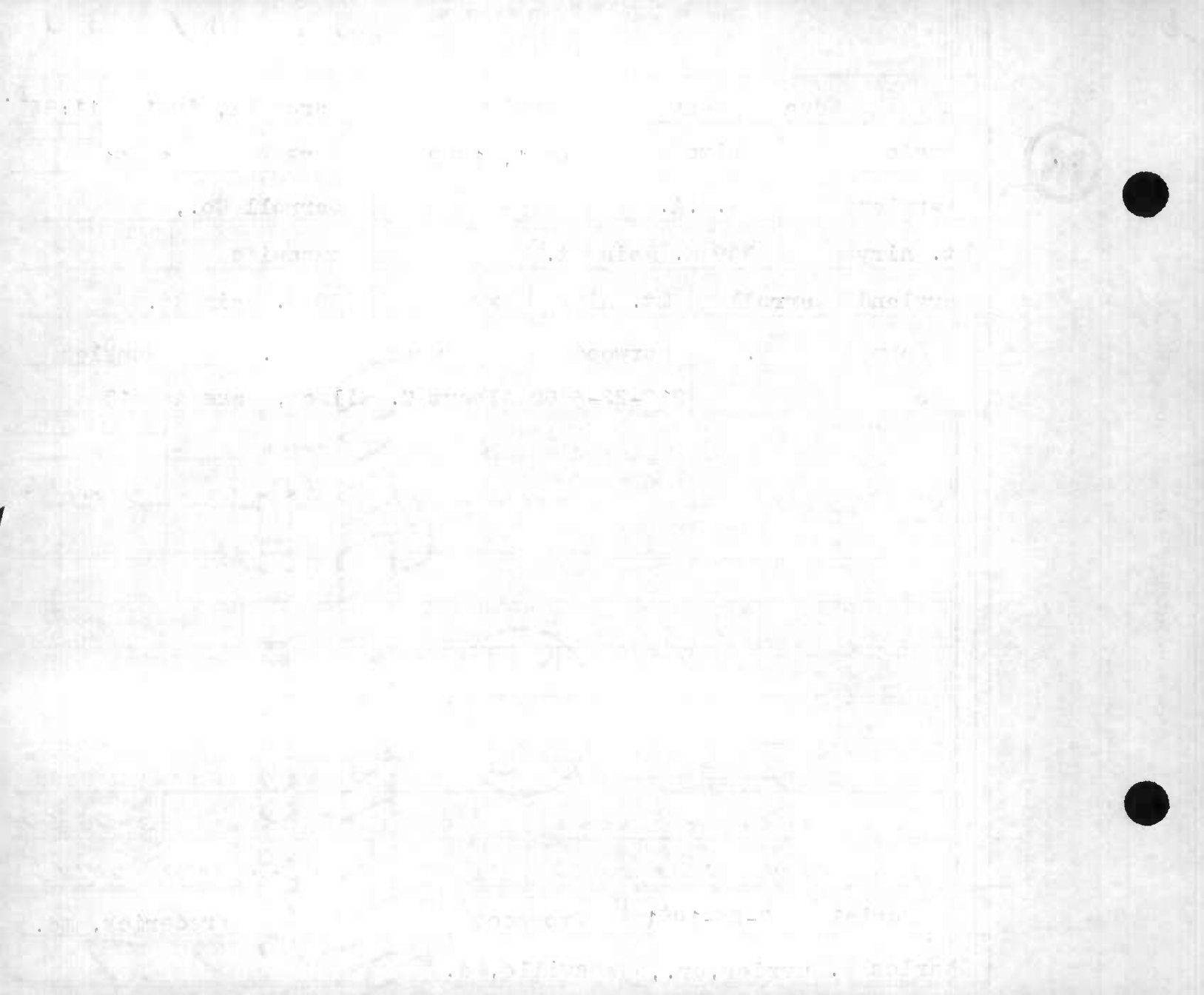
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edna May Murphy | | | 2a. DATE OF DEATH MONTH DAY YEAR March 22, 1981 | | | 2b. HOUR 11:35 P.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 1, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 10 21 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD. | | | |
| 10. CITY OR TOWN OF DEATH Mt. Airy | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 309 N. Main St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Mt. Airy | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John T. Norwood | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan E. Runkles | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-22-5800 | | 17. INFORMANT ADDRESS Albert C. Wilson, Same As #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>generalized carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Months</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-18</u> , 19 <u>78</u> , to <u>3-22</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ephraim Barzaga | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 3-23-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EPHRAIM BARZAGA | | | 22e. ADDRESS NEW WINDSOR, MD. 21776 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 3-25-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Prospect | | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Md. | | |
| 24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md. | | | ADDRESS | | | 25. DATE REC'D BY REGISTRAR (U.S. REGISTRAR'S SIGNATURE) MAR 26 1981 | | | |

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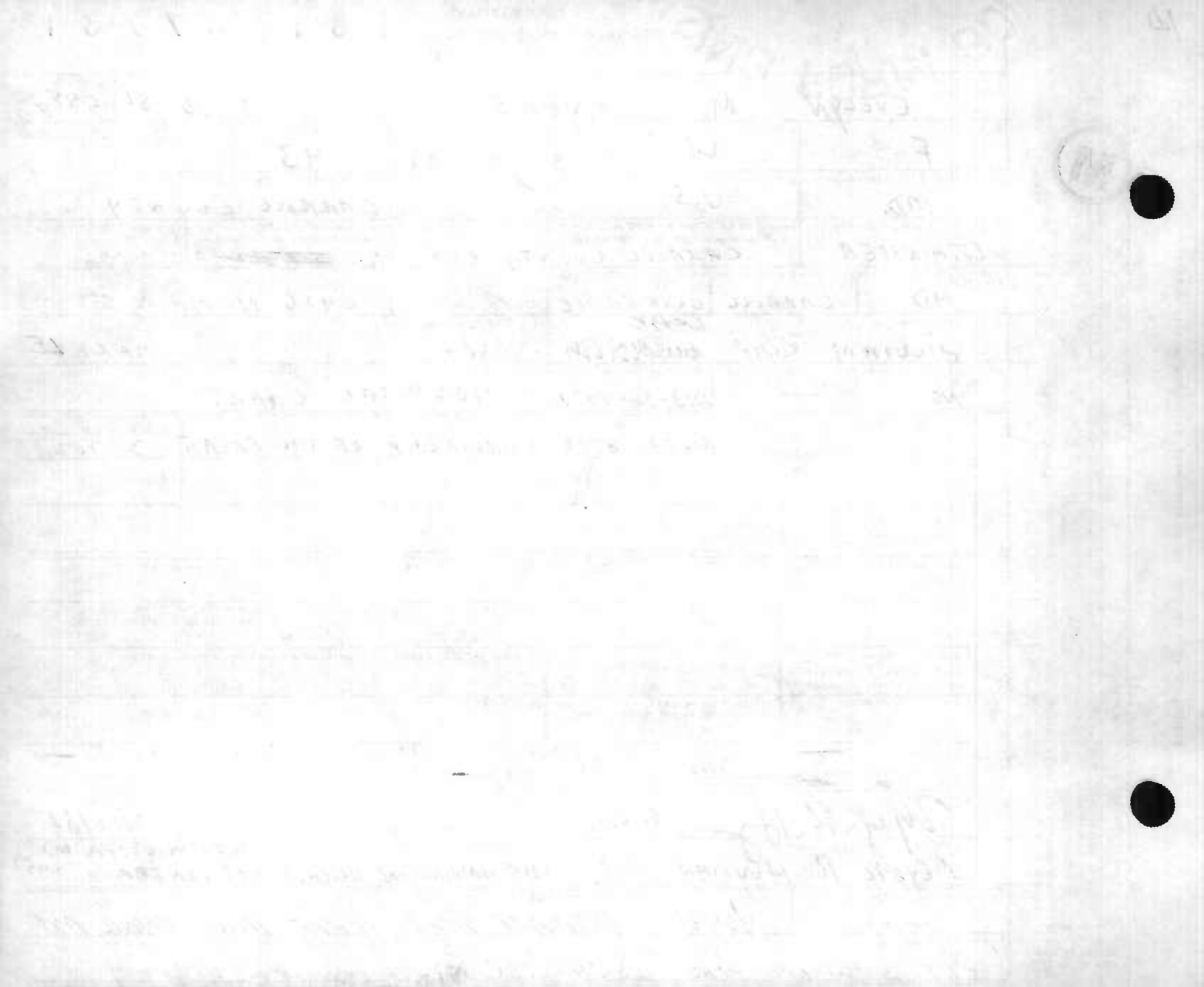
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 7 7 3 1 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EVELYN M. MYERS | | | | 2a. DATE OF DEATH MONTH 3 DAY 16 YEAR 81 | | 2b. HOUR 545 PM | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH 3 DAY 7 YEAR 38 | | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH WESTMINSTER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GEN | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK | | 12b. KIND OF BUSINESS OR INDUSTRY SCHOOL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN UNION BRIDGE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST WILLIAM MIDDLE KUMP LAST LEPP | | 15. MOTHER'S MAIDEN NAME FIRST HILDA MIDDLE MARKLE LAST MARKLE | | 13e. STREET ADDRESS 6426 N. MAIN ST. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-36-9474 | | 17. INFORMANT ADDRESS HOSPITAL CHART | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE BREAST 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MOS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/11 19 81 , to 3/16 19 81 , that (I) did not saw the deceased alive on 3/16 19 81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not (did) view the body after death. | | | | | | | |
| 22b. SIGNATURE Meyer R. Heyman M.D. DEGREE M.D. | | | | 22c. DATE SIGNED 3/16/81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEYER R. HEYMAN MD. | |
| 22e. ADDRESS 215 WASHINGTON HEIGHTS MED CENTER | | | | 22f. CITY OR TOWN WESTMINSTER MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/20/81 | | 23c. NAME OF CEMETERY OR CREMATORY PLEASANT VALLEY | | 23d. LOCATION CITY OR TOWN COUNTY STATE PLEASANT VALLEY CARROLL MD | |
| 24. FUNERAL DIRECTOR NAME PRITTS FUNERAL HOME ADDRESS WESTMINSTER, MD | | | | 25a. DATE REC'D. BY REGISTRAR MAR 23 1981 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE History McCreedy | | | |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified since.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 7. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | |
| Lewis A. Myers | | | | 3 19 81 2150 M | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. | |
| Male | | White | | April 10, 1900 | | 80 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S.A. | | | | CARROLL MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Westminster | | CARROLL Co. Hospital | | Contractor | | Building | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? | | | |
| 13a. STATE COUNTY | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Md. CARROLL Finksburg | | | | 13b. STREET ADDRESS | | | |
| | | | | 3902 Sykesville Rd. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Jesse W. Myers | | | | Anna Burns | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO | | | |
| No | | | | 918-14-8042 | | | |
| 17 INFORMANT | | | | ADDRESS | | | |
| Robert Myers - Sykesville | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY. | | | | | | | |
| IMMEDIATE CAUSE (a) PROGRESSIVE MYOCARDIAL ISCHEMIA | | | | | | | 48 HOURS |
| 4140 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) ATHEROSCLEROTIC CORONARY HEART DISEASE | | | | | | | YEARS |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/18, 19 81, to 3/19, 19 81, that (I) (we) last saw the deceased alive on 3/19, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Vincent P. Fiocchio Jr. MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 3/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Vincent P. Fiocchio Jr. | | | | Westminster, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 3-23-81 | | Trinity Lutheran Cemetery | | Smallwood Carroll Md. | |
| 24 FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Harry W. Knight Sykesville, Md. | | | | MAR 26 1981 | | | |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 7 / 3 3

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|--|-----------------|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT E. PIERCE | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 21 81 | | 2b. HOUR A M | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 20 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1321 Streaker Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Checker | | 12b. KIND OF BUSINESS OR INDUSTRY Local Union Steamship Trade Assoc. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 21223 1937 Christian Street Balto., Md. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert M. Pierce | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 214-01-0904 | | 17. INFORMANT 21228 ADDRESS Robert J. Pierce, Jr. 6009 Chesworth Rd. Catonsville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 1419 IMMEDIATE CAUSE (a) <i>Cardiomyopathy - liver failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>hepatic metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sp. Cr. lobe of brain</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>2 mths</i> <i>29 mths</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Coronary Artery</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION 4/17/79 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Artery | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/1/79 to 3/22/81, that (I) (we) lost saw the deceased alive on 3/15/81, and that in (my) (our) opinion death occurred on the date and hour from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>R. G. Chambers</i> | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 3/23/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert G. Chambers | | | | 22e. ADDRESS 2310 McComas Rd. White Hall, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Mausoleum | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Avenue | | | | Baltimore, Md. 21229 | | 25a. DATE REC'D. BY REGISTRAR MAR 24 1981 | | 25b. REGISTRAR'S SIGNATURE <i>P. J. Kelly</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nettie Elizabeth Poole | | | 2a. DATE OF DEATH MONTH DAY YEAR March 21, 1981 | | 2b. HOUR P. M. 1:45 | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 9, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 84 2 12 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD. | | | |
| 10. CITY OR TOWN OF DEATH Mt. Airy | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2518 Flag Marsh Rd. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Mt. Airy | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William O. Porter | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Pickett | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-48-2462 | | 17. INFORMANT Alva R. Poole, Mt. Airy, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and Atherosclerotic 4029 DUE TO, OR AS A CONSEQUENCE OF Cardiovascular Disease (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 years | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 19 69 , to March 19 81 , that (I) (we) last saw the deceased alive on March 9 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE W.B. Culwell, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3/23/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Culwell MD | | | | | | 22e. ADDRESS Mt. Airy, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 3-24-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Pine Grove | | 23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Carroll, Md. | | |
| 24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., | | | | | | ADDRESS Sykesville, Md. | | 25a. DATE RECEIVED BY REGISTRAR MAR 26 1981 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

1100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after a person dies. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8107735 | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROY William SEAL | | | | 2a DATE OF DEATH MONTH DAY YEAR MAR 27 81 | | | | 2b HOUR 0200 | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR April 26, 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 7c IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL Co. Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grounds Keeper | | 12b KIND OF BUSINESS OR INDUSTRY Self Employed | | | |
| 13a STATE Md. | | | | 13b COUNTY CARROLL | | 13c CITY OR TOWN Mt. Airy | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS Rt 7 Box 86 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Thomas Seal | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tabatha Green | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO 579163177 | | 17 INFORMANT Willie Seal | | ADDRESS Mt. Airy, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4360 Cardiorespir. arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) central brain damage (c) hypotension | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Prior CVA's - aspiration pneumonia | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3-21, 1981, to 3-27, 1981, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Susan K. Sekely, M.D. | | | | | | DEGREE M.D. | | 22c DATE SIGNED | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN K. SEKELY, M.D. | | | | | | 22e ADDRESS 215 Washington Heights, MED. CENTER, WESTMINSTER, MD 21157 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b DATE 3-30-81 | | 23c NAME OF CEMETERY OR CREMATORY True Hosp. Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Frederick Howard Md. | | | |
| 24 FUNERAL DIRECTOR NAME Harry W. Haight | | | | | | ADDRESS Lukensville Md. | | 25a DATE REC'D. BY REGISTRAR APR 1 1981 | | 25b REGISTRAR'S SIGNATURE | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

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|--|--|--|---|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) ROBERT EDWARD SELL | | | 2a. DATE OF DEATH MONTH 03 DAY 30 YEAR 81 | | | 2b. HOUR 9:35 A M | | | |
| 3. SEX male | | 4. RACE caucasian | | 5. DATE OF BIRTH MONTH 09 DAY 26 YEAR 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 64 MONTHS 6 DAYS 4 | | 7. IF UNDER 1 YEAR HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll County | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD | | | |
| 10. CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 322 Stoner Ave | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber | | 12b. KIND OF BUSINESS OR INDUSTRY Crouses Barber Shop | | | |
| 13a. STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Westminster | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 322 Stoner Avenue | |
| 14. FATHER'S NAME FIRST Oscar MIDDLE David LAST Sell | | 15. MOTHER'S MAIDEN NAME FIRST Adah MIDDLE Elizabeth LAST Bankert | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | | | | |
| 16b. SOCIAL SECURITY NO. 212-01-7461 | | 17. INFORMANT Maxine L. Keilholtz 17343 N. Seton Ave | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) COPD | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 72 , to March 19 81 , that (II) (we) lost saw the deceased alive on March 26 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dean H. Griffin | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 03-30-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dean H. Griffin, M.D. | | | | 22e. ADDRESS 19 Ridge Road Westminster, MD 21157 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/3/81 | | 23c. NAME OF CEMETERY OR CREMATORY Krider's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md. | | | |
| 24. FUNERAL DIRECTOR NAME Cal Hotel | | 24b. ADDRESS 254 East Main St. Westminster, Md. 21157 | | 25a. DATE REC'D. BY REGISTRAR APR 3 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
1 - STATE
REGISTRAR

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|--|--|--|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Mai Buchanan Srygley</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>3-26-81</i> | | | 2b. HOUR <i>5:50 AM</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>11-1-1894</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Tennessee</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> | |
| 10. CITY OR TOWN OF DEATH <i>Westminster</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Md.</i> | | 13b. COUNTY <i>Carroll</i> | | 13c. CITY OR TOWN <i>Hareytown</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Buchanan</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca Coss</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | |
| 16b. SOCIAL SECURITY NO. <i>---</i> | | 17. INFORMANT ADDRESS <i>Nancy S. Briscoe 4300 Babylon Rd. Hareytown Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <i>1749 IMMEDIATE CAUSE (a) Terminal Breast Carcinoma</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ </div> <div> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ </div> </div> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Dehydration, MALNUTRITION, DECUBITUS ULCER</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/24</i> , 19 <i>81</i> , to <i>3/26</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3/26</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Manuel J. Sevilla</i> | | | | DEGREE <i>MD</i> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MANUEL J. SEVILLA</i> | | | | 22e. ADDRESS <i>419C Malcolm Rd Westminster Md.</i> | | | |
| 23a. BURIAL (SPECIFY) <i>Cremation</i> | | 23b. DATE <i>3-27-81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Westview</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Thomas J. Fletcher Jr.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAR 30 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MADE IN U.S.A.



MOORE & WOOD

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07738 | |
|--|------------------|--|---|---|---|--|--|--|-----------------------|---|---------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Eugene Weant Stambaugh | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> March 17, 1981 | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 16, 1930 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 50 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD March 17, 1981 | 2d. HOUR 1:00 p.m. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD | | | | | |
| 10. CITY OR TOWN OF DEATH Taneytown | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5435 Bowers Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergyman | | 12b. KIND OF BUSINESS OR INDUSTRY Religion | | | |
| 13a. STATE Penna. | | | | | | | | | | 13b. COUNTY Juniata | 13c. CITY OR TOWN Port Royal |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 404 Main Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Stambaugh | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rena Mae Weant | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-30-6313 | | 17. INFORMANT ADDRESS 404 Main Street Mrs. Kay Stambaugh Port Royal, PA 17082 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Richard A. Jones</i> | | | M.D. Deputy | | TITLE (SPECIFY) Carroll County General Hospital | | DATE SIGNED 3/17/81 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones, M.D. | | | ADDRESS Westminster, MD 21157 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Mar. 21, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll, Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME Skiles Funeral Home | | | 136 E. Baltimore St. Taneytown, MD 21787 | | 25a. DATE REC'D. BY REGISTRAR MAR 23 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Barry J. ...</i> | | | | |

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

| | | | |
|------------|---------------|------|------------|
| NAME | WHITE, JUDITH | DATE | 1980-07-20 |
| ADDRESS | 1111 | | |
| TELEPHONE | 2432 | | |
| EDUCATION | High School | | |
| EMPLOYMENT | None | | |
| EXPERIENCE | None | | |
| REMARKS | No. 1-1-1012 | | |

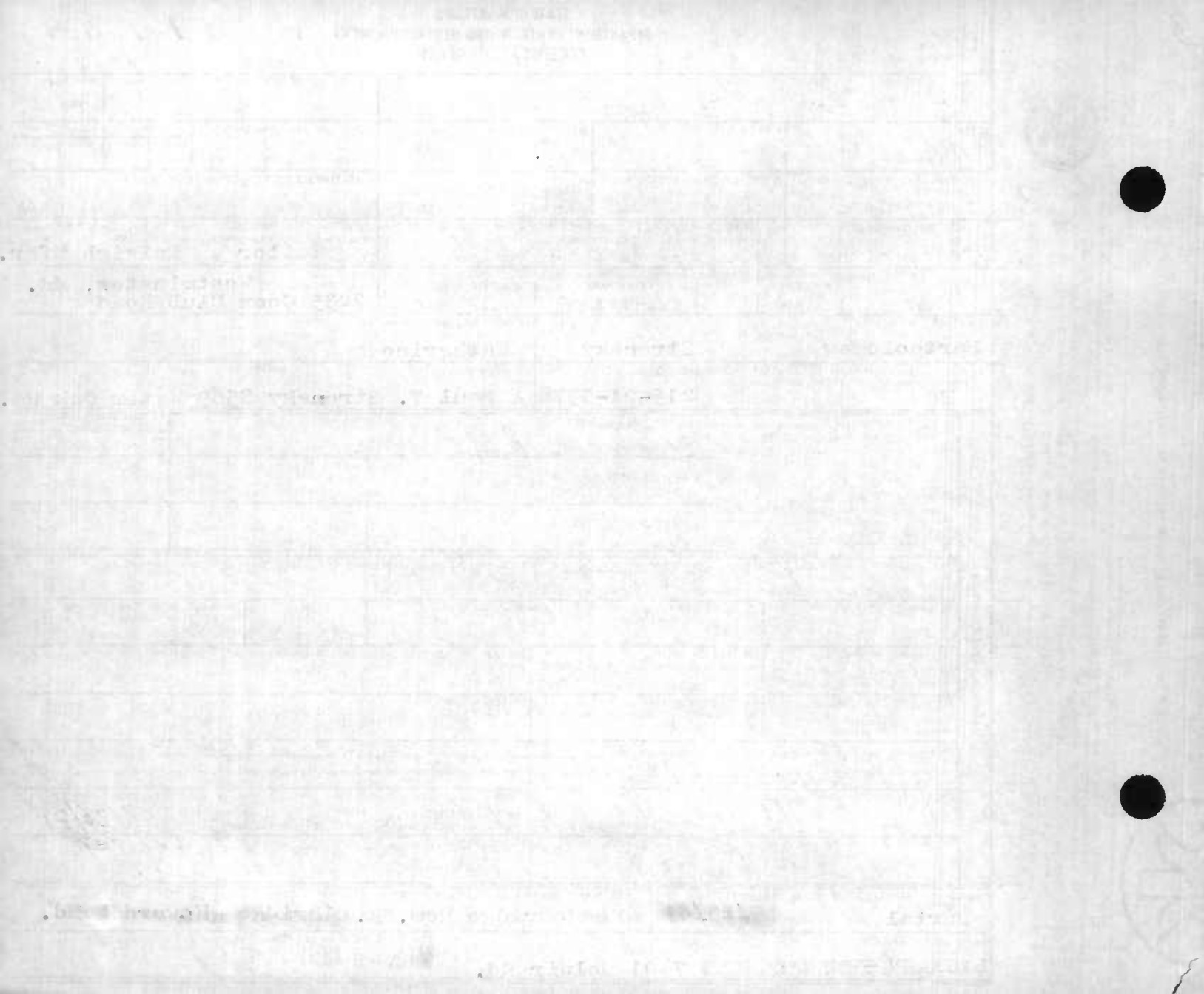
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| TEST RESULTS | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|--------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|---|---|---|--|-----------------------------------|---------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 07739 | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2b. HOUR | | | | | |
| George Bernard Stronsky | | | | | 3-20-81 9P M | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | |
| MALE | | WHITE | | MONTH DAY YEAR 12 11 94 | | 86 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Baltimore | | USA | | | | Cannell MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Westminster | | Westminster Nursing & Conv. Center | | | | Tailor | | Kaleigh Mfrg. | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | |
| Md | | | | | Cannell | | Westminster | | 2235 Coon Club Road | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Bartholomew Stronsky | | | | | Katherine | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | | 215-01-5378 | | A Paul W. Stronsky 8569 Water Oak Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of the lung | | | | | | | | | | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| Congestive heart failure | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/3 19 80, to 3/20 19 81, that (I) (we) lost saw the deceased alive on 3/20 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) [did; did not] view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | 22c. DATE SIGNED | | | | | |
| Norman A. Poulsen MD | | | | | 3/20/81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | |
| NORMAN A. POULSEN | | 218 WASH. HIGTS. MED. CENTER WESTMINSTER, MD. 21157 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 3/23/81 | | Meadowridge Mem. Pk. | | Elkridge Howard Md. | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| LASSAUN FUNERAL HOME 7401 Belair Rd. | | | | | MAR 26 1981 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 81 07740 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 3 1981 | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Fay Sykes | | | | 2b. HOUR 1306 M | | | |
| 3 SEX Female | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 04 10 08 | | 6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD. | |
| 10 CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria | | 12b KIND OF BUSINESS OR INDUSTRY B&D | |
| 13a STATE Maryland | | 13b COUNTY Carroll | | 13c CITY OR TOWN Hampstead | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Constant E Elseroad | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Milligan | | 13e STREET ADDRESS 2009 Hanover Road | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b SOCIAL SECURITY NO 216-03-9794 | | 17 INFORMANT ADDRESS Mrs. Betty Rohde, Reisterstown, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Feb 23, 1981, to Mar 3, 1981, that (I) (we) last saw the deceased alive on Mar 3, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE John S. Harshey, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 3/3/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, MD | | | | 22e ADDRESS 6 Avenue St. Westminster, Md. 21157 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 3-5-81 | | 23c NAME OF CEMETERY OR CREMATORY Wesley Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md. | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home, Hampstead, Md. 21074 | | | | 25a DATE REC'D. BY REGISTRAR MAR 6 1981 | | 25b REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician.

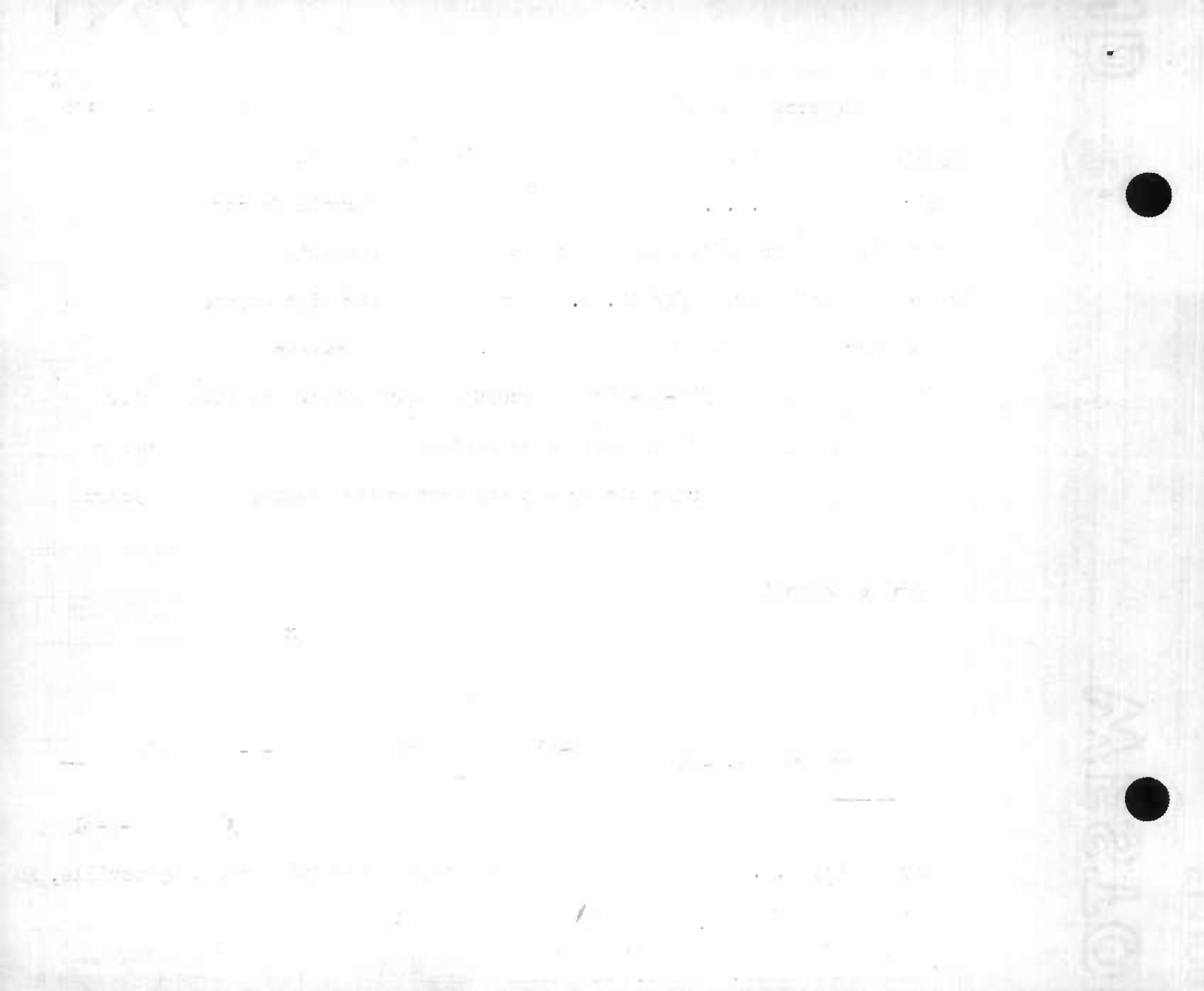
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8107741 | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Rebecca (NMN) Tenn | | | | 2a. DATE OF DEATH MONTH DAY YEAR 03 02 81 | | | |
| 3 SEX Female | | | | 4 RACE White | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR 19 07 97 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 84 YRS | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | | | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD. | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Springfield Hospital Center | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY at home | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | | |
| 13c. CITY OR TOWN Yesil.Sp. | | | | 13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN MENDEL GIMBLE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 579-40-4739 | | | |
| 17. INSTRUCTIONS TO RECORDS WILLIAM TENN 603 GIST AVE. SILVER SPG., MD | | | | 17. INSTRUCTIONS TO RECORDS Records: Springfield Hospital Center 20910 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Senile dementia | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Senile dementia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-13 19 80 , to 3-2 19 81 , that (I) (we) lost saw the deceased alive on 3-2-81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Suha Ozgun, M.D. | | | | DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3-2-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Suha Ozgun, M.D. | | | | 22e. ADDRESS Springfield Hospital Center, Sykesville, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL | | 23b. DATE 3/4/81 | | 23c. NAME OF CEMETERY OR CREMATORY COVERDALE (YOD CHARUTVIN) | | 23d. LOCATION CITY OR TOWN COUNTY STATE CINCINNATI, OHIO | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 6 1981 | | 25b. REGISTRAR'S SIGNATURE Barney Maloney | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | |

BP

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 / 4 2 | |
|--|--|--|--|--|---|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Jessie E. Welsh</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>3 20 1981</i> | | 2b. HOUR <i>10:00 A</i> |
| 3 SEX <i>F</i> | 4 RACE <i>W</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>3 16 05</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD. | |
| 10 CITY OR TOWN OF DEATH <i>Westminster</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Westminster Nursing Home</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Weaving</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>CLOTHING</i> |
| 13a. STATE <i>Md.</i> | | | 13b. COUNTY <i>Carroll</i> | 13c. CITY OR TOWN <i>Westminster</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Martico Welsh</i> | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margie E. Davis</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>n/a</i> | | 17. INFORMANT ADDRESS <i>Sara Catherine Zepp s/a</i> | |
| 18 CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>6 years</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>2/15</i> 19 <i>75</i> , to <i>3/20</i> 19 <i>81</i> , tho (1) (we) lost saw the deceased alive on <i>3/19</i> 19 <i>81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Julius Chepko MD</i> | | DEGREE <i>MD</i> | | 22c. DATE SIGNED <i>3/20/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Julius Chepko MD</i> | | 22e. ADDRESS <i>854 W Green St Westminster, MD 21157</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i> | | 23b. DATE <i>3/24/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Deer Park Cemetery</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Smallwood Carroll Md</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Pritts Funeral Home</i> | | ADDRESS <i>Westminster</i> | | 25a. DATE REC'D. BY REGISTRAR <i>MAR 30 1981</i> | |
| 25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i> | | | | | |



General
C. J. ...

John ...
C. J. ...
John ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 7 7 4 3

1. FOR
STATE
REGISTRAR

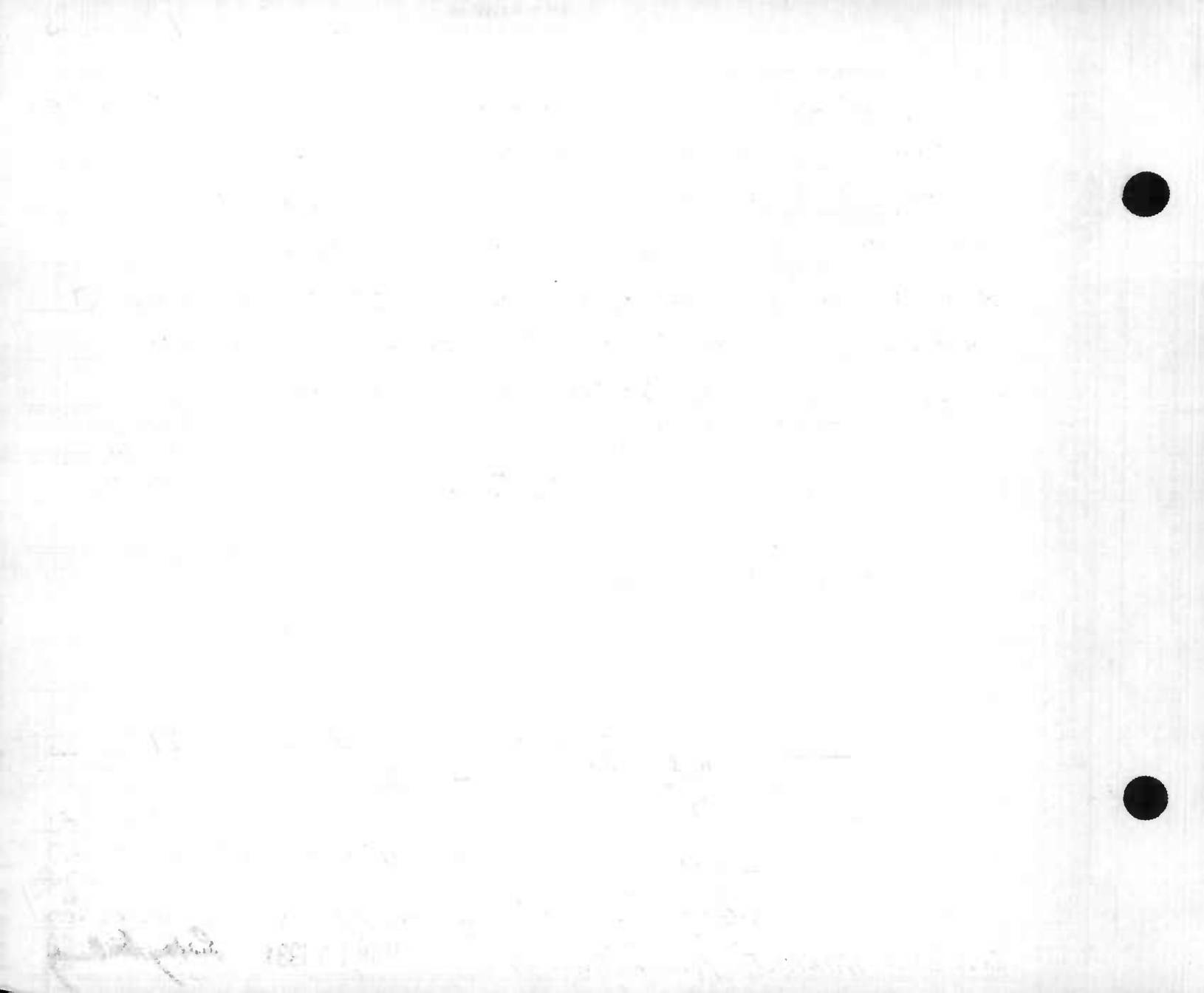
REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES C. WHORTON | | | 2a. DATE OF DEATH MONTH DAY YEAR March 3 1981 | | | 2b. HOUR 6:20 A M | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 4 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS None | | 8. IF UNDER 24 HRS HOURS MIN None | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9b. CITIZEN OF WHAT COUNTRY? U.S.A | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD. | | | | | |
| 12. CITY OR TOWN OF DEATH Sykesville | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 15. KIND OF BUSINESS OR INDUSTRY | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 329 W. Antietam St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Whorton Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Nicholas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-74-9221 | | 17. INFORMANT Hospital records. | | | | ADDRESS | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - 3459 DUE TO, OR AS A CONSEQUENCE OF (b) Epilepsy DUE TO, OR AS A CONSEQUENCE OF (c) Mental Retardation. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years. | |
|---|--|--|--|

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Mental Retardation. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-17-43 19 81 , to 3-3 19 81 , that (I) (we) lost saw the deceased alive on March 3 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Silabym. r. d. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 3-3-1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUHA OZGUN | | | | 22e. ADDRESS Springfield Hospital, Sykesville, Md. | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-6-81 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery, Hagerstown | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR NAME Gerald N. Minnich | | | | 25. DATE RECD. BY REGISTRAR MAR 13 1981 | | 25b. REGISTRAR'S SIGNATURE Anthony... | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 7 4 4 | | | |
|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 20. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | | 2b. HOUR | | | |
| mamie H. Wilhelm | | | | 3/ 19/ 81 | | | | 250 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| F | | Cauc | | MONTH DAY YEAR 2 9 1898 | | 83 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Balt. Co. | | U.S.A. | | | | CARROLL MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Manchester | | Longview Nursing Home | | | | | | Leonard Greif Co. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| md. | | Balt. | | Balt. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 511 Windwood Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| George W. Wilhelm | | | | Ida V. Hale | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | 217-01-7788 | | Josey | | Balt. Md. 21212 511 Windwood Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 2738 DUE TO, OR AS A CONSEQUENCE OF (b) NEPHROTIC SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c) HYPOPROTEINEMIA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| COMPLETE HEART BLOCK WITH PACEMAKER. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/18/81, 19, to 3/19/81, 19, that (I) (we) last saw the deceased alive on 3/18/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Myers | | | | | | | | 3-19-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| S.D. MORTAJARIA | | | | 3125 MAIN STREET, MANCHESTER MD. 21102 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| Burial | | 3-21-81 | | Forest Cemetery | | Upperco | | Balto | | Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. SIGNATURE | | | | | |
| Eline Funeral Home, Hampstead, Md. 21074 | | | | MAR 23 1981 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 335-6000.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 0 | 7 | 7 | 4 | 5 |
|--|--|--|---|--|--|--|--|---|---|--|------------------------|---|---|------------------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Edward William Will, Sr. | | | | | | | | | | 2a. DATE OF DEATH March 29, 1981 | | | | 2b. HOUR 0843 M | | |
| 3 SEX Male | | | 4 RACE White | | | 5 DATE OF BIRTH Oct. 12, 1910 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | | 7 UNDER 1 YEAR MONTHS 5 DAYS 17 | | 8 UNDER 24 HRS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH Westminster | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp. | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman | | | 12b. KIND OF BUSINESS OR INDUSTRY Gas & Electric | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Carroll 13c CITY OR TOWN Westminster | | | | | | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 3615 Ridge Road | | | | |
| 14 FATHER'S NAME FIRST Albert MIDDLE Will LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST Molly MIDDLE McJilton LAST | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO 212-05-3499 | | | 17 INFORMANT Eva M. Will, Same As #13 | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from March 12, 1981, to March 27, 1981, that (I) (we) last saw the deceased alive on March 29, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b SIGNATURE John S. Harshey, MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c DATE SIGNED 3/27/81 | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY MD | | | | | | 22e ADDRESS 8 Andover St. Westminster, Md. 21157 | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 4-1-1981 | | | 23c NAME OF CEMETERY OR CREMATORY Lake View Memorial | | | 23d LOCATION CITY OR TOWN | | COUNTY Carroll, Md. | | | | | |
| 24 FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md. | | | | | | 25a DATE REC'D. BY REGISTRAR APR 1 1981 | | 25b REGISTRAR'S SIGNATURE Marilyn McCreedy | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8107146 | |
|--|-------------------------|---|--|---|--------------------------|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie Irene Winter | | | 2a. DATE OF DEATH MONTH DAY YEAR March 12, 1981 | | 2b. HOUR 9:45a |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR April 18, 1877 | | 6. AGE (IN YEARS LAST BIRTHDAY) 103 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD | | 10. CITY OR TOWN OF DEATH Taneytown | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 114 West Baltimore Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Taneytown | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Shriner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Myerly | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-54-4346 | | 17. INFORMANT Carrie V. Winter | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4/40 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (1) (this hospital) attended the deceased from July 3, 1981 to Mar 11, 1981 , that (1) (we) lost saw the deceased alive on 3-11-81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Gregorio C. Marfori | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3-13-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregorio C. Marfori | | 22e. ADDRESS 49 Frederick St. Taneytown, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Mar 14, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll, Maryland | | 24. FUNERAL DIRECTOR NAME Skiles Funeral Home | | | |
| 24. FUNERAL DIRECTOR ADDRESS 136 E. Baltimore St. Taneytown, MD 21787 | | 25a. DATE REC'D. BY REGISTRAR MAR 16 1981 | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

